Maternal and Child Health Services
Title V Block Grant

State Narrative for Kentucky

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications for the Title V, Maternal and Child Health Block Grant are on file in the office of the Division of Maternal and Child Health. The division office can be contacted at 502-564-4830.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input for the Title V Block Grant is accomplished in many ways.

The Department for Public Health submits two copies of the Title V/Maternal and Child Health Block Grant application to the Legislative Research Commission (LRC) of the Kentucky General Assembly. After the grant submission each July, DPH presents testimony about the Block Grant to the Health & Welfare legislative committee each year before they approve the grant.

A link to the Title V/Maternal and Child Health Block Grant, as well as program service information, is on the Department for Public Health Website. A public hearing is scheduled annually for the DPH block grants, during July, prior to submission of the application. Information about the Title V Application process, overview of the purpose and data compared over multiple years is provided. A news release is sent from the CHFS Office of Communications to media within the state announcing the date and location of the public hearing. Title V staff are in attendance and are available for questions at each hearing. However, this is not the process through which the Title V Program obtains most of the public input.

DPH conducted 11 forums throughout the state in March -- May of 2009 that were attended by over 500 interested stakeholders, including LHD directors, CHFS partners, contractors, and providers. The forums covered many topics that were of interest to stakeholders since they had been identified by them through a web-based survey conducted prior to the forums. DPH distributed surveys in health departments in order to hear the voice of clients who are being provided services under Title V Block Grant. Surveys were available in English and Spanish. We received 3,200 completed surveys from patients that are currently being analyzed.

DPH distributes other surveys on a continuing basis in order to receive input from the populations served. The HANDS Parent Satisfaction survey is distributed annually in March. Surveys cover enrollment, interview process, and quality of services. First Steps surveys are mailed out annually in July to elicit information from parents reporting if they are being helped by the program, if families know their rights, and if families can effectively communicate their children's

needs and help them develop and learn.

The Division's program staff participate in many organizations, workgroups and committees across the state related to their programs which include their stakeholders, community partners, and consumers. Those efforts include, but are not limited to; the First Steps Interagency Coordinating Council (includes parent representatives and receives input from the public during quarterly meetings); the Kentucky Childhood Lead Poisoning Prevention Advisory Board which receives input from stakeholders and community partners; The Breast Cancer Advisory Committee; the Coordinated School Health Program which receives input from the public as well as community partners; Early Childhood State Advisory Committees (SEED, ECCS); State Interagency Coordinating Council for Services to Children with an Emotional Disabiity (includes teen and parent representatives);Partnership for a Fit Kentucky state coalition; Action for Healthy Kids; Community Early Childhood Councils; and Summits such as the Breastfeeding Summit and Teen Pregnancy summits held in Spring 2010. These interactions with public and private partners provide ongoing feedback and guidance to the Title V MCH program.

The Commission for Children with Special Health Care Needs also obtained input from a wide range of people for their needs assessment, including their Youth Advisory Council, Parent Advisory Council, Parents as Partners, and Medical Advisory Council. On an ongoing basis, CCSHCN staff participate on councils and boards such as the KY Council on Disabilities, Center for Accessible Living, KY Speech-Language & Hearing Assiciation, Regional Interagency Transition teams, KY Special Parent Involvement Network (KSPIN), First Steps ICC, KY Interagency Transition Council for Persons with Disabilities, and others.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Kentucky began the Title V Needs Assessment process with a Technical Assistance training on March 24, 2008. The topics covered included an overview of needs assessment, assessment and priority setting of health issues, examples of needs/assessment/prioritization models used by other states, themes across states, and next steps. From the technical assistance a draft logic model and timeline were developed for the needs assessment process.
To assess the MCH target populations, three tools were used: a Web-based Provider Survey, Community Forums, and a Statewide Patient Survey. Respondents of the web-based provider survey numbered 1,398 and from the Statewide Patient Survey there were approximately 3,200. DPH conducted 11 community forums throughout the state within a 3-month period. Priorities were determined through the triangulation method to ascertain cross-cutting themes and results. The top nine issues in order of rank included: Substance Abuse and Drug Abuse, Teen Pregnancy, Overweight and Obesity, Smoking (including second-hand smoke), Dental/Oral Health, Mental Health and/or Depression, Health Insurance Coverage, Child Abuse, and Breastfeeding. The needs assessment document summarizes extensive input from stakeholders in Kentucky.

As a result of the 2009 community forums, it is clear that substance abuse has risen to the # 1 priority in communities across Kentucky. Although this is not within the responsiblities of the MCH Title V Director, the need cannot be ignored. Substance abuse treatment options, especially for pregnant women, are limited. The state lacks consistent availability for all populations and has no data that relects the true extent of the problem. DPH is now working with the Department for Behavioral Health, Developmental and Intellectual Disabilities to address this by sharing data and information. The Home Visiting Needs Assessment will provide more discussion on this subject.

Smoking has long been a target of KY public health initiatives and now these efforts are starting to pay off.
Kentucky now has Smoke Free Policy enacted in 27 cities/counties that affect close to 38% of the population in the state. The tobacco tax has been raised twice. The GIFTS program (Giving Infants and Families a Tobacco-Free Start) has demonstrated positive outcomes in pregnant women who are heavy smokers, and is now being expanded. Despite difficult fiscal constraints, the 2010 legislature funded Smoking cessation counseling to Medicaid enrolled persons. Yet KY has the second highest rate of smoking in pregnancy in the country, so this remains a priority.

Teen pregnancy in KY has followed national trends and was not a high priority until the community forums, where it was one of the most discussed topics. Clearly, communities feel this is a major problem, and a symptom of the needs of youth in our communities. Women's Health is finding innovative ways to address the concern of teen pregnancy, working closely with communities and multiple professional partners. Funding from Health Care Reform may be available to enhance Kentucky's capacity to meet this need.

Obesity has been a public health priority since state-wide forums in 2005, but Kentucky continues to show a rise in obesity in children. There are a number of capacity measures in place through university partners, local pediatricians and in communities through the Partnership for a Fit Kentucky. Legislators are aware of the growing concern and have proposed mandatory physical activity in schools which has not passed yet. The CCSHCN has chosen to supplement DPH in efforts to address obesity because of the unique mental and physical needs of the populations

they serve. The CCSHCN plans to address healthy nutrition and weight during the face-to-face contact in medical clinics and the ability of their staff to affect growth and change. This is a logical expansion for the commission based upon internal capacity, staff experience and selection of the priority from the needs assessment process.

In 2009 Kentucky ranked #1 in child deaths from child abuse and even though this has been a priority need for quite some time, it is at a higher level of importance. Because of this we are partnering with the Division of Protection and Permanency and the Dept. of Behavioral Health, Developmental and Intellectual Disabilities to develop new approaches.

Access to oral health care continues to be an issue for Kentucky, especially for pregnant women and low income children. The Kentucky Oral Health Program is building a stronger capacity to address these concerns, specifically for increasing dental services to pediatric patients and pregnant women.

Kentucky will continue to prioritize infant mortality and prematurity as a core MCH measure of well-being of women of childbearing age, and improving pregnancy outcomes. Newer apporaches involve addressing contextual and comunity factors as well as the traditional risk factors.

The CCSHCN continues to address the need to incorporate into practice transition services for youth. Although 82% of CCSHCN clients report having no transition services, when asked again using different language there are more who report having some type of transitions services. This is a priority going forward into 2010.

III. State Overview

A. Overview

The Commonwealth of Kentucky, nicknamed the Bluegrass State, became a state in 1792, the 15th of the United States. Kentucky has a diverse terrain comprised of the Appalachian Mountain range to the east, fertile interior lowlands within the Bluegrass central area, and plateau to the west. The state is bounded by two of the largest rivers in the country, the Ohio River to the north and the Mississippi River to the west. Kentucky is rich in agriculture ranking 5th in the nation for total number of farms per square mile. It maintains a farm-based economy in major crops of corn, soybeans and tobacco. The state is the leading breeder of thoroughbred racing horses and cattle and goat production rank 8th and 5th respectively in the nation. Industrially coal mines in the state are the most productive in the nation and Kentucky ranks 4th among U. S. states in the number of automobiles and trucks assembled.

There are 120 counties within the state that vary greatly in size, terrain, population, culture, and education. Much of Kentucky is rural, with nearly 2/3 of the 120 counties in the state not having a city or town with over 20,000 people. Even with sparsely populated areas, nearly half of Kentucky's population (42%) live in rural areas. This affects access to health care, access to higher education, access to employment, and access to services. There are 56 Appalachian counties designated by the CDC as a disparate population where poverty rates and these geographic challenges make access to care difficult and result in higher morbidity and mortality.

Kentucky's total population is 4,269,245 (2008, Census Bureau) with a growth rate of almost 5.6% over the last eight years. As the population grows, it is becoming more racially and ethnically diverse. Overall, whites comprise 89% of Kentucky's population, African-Americans represent 7.7%, and Hispanic 2.5%. Other groups comprise less than 2% of the population. However, KY's children are more diverse with 84% white, 10% black, and 4% Hispanic (Kaiser). A snapshot of CCSHCN's population of 8439 patients seen during FY 2009 data shows a distribution: 82% white (including an under 1% Amish), 8.4% Black/African-American, 5% Hispanic, just under 1% Asian, and 3.4% "some other race/combination"; and 95% English speakers, 3.5% Spanish speakers, <1% sign language, and 20 primary languages used by clients.

By most every measure, the health status of Kentuckians ranks in the lower half, frequently the lower quartile in the nation. The framework of the Life Course Perspective of Health Development (Lu and Halfon, 2003) is helpful in understanding this. The Life Course model plots a course for a person's or a population's health trajectory across the life span. The slopes of the trajectory of health status at different life stages are determined by the balance of the number of protective factors (upward arrows) that "push up" and risk factors (downward arrows) that "push down" on the trajectory. Along this trajectory, there are critical periods of development, times at which toxic metabolic or social environments and adverse experiences can disrupt development and result in impaired functioning of an organ or system for the rest of the person's life. However, when persistently experiencing these adverse experiences over the life course as chronic stressors, there is a cumulative "wear and tear" on the body, depleteing the allostatic system (the body's ability to adjust to stress). Thus, chronic and repeated stresses over the life course may lead to increased risk for cardiovascular diseases, cancers, higher mortality rates, autoimmune disorders, and a host of chronic adult diseases that contribute to poor health status and health disparities.

In MCH, we are particularly aware of the critical periods of development and the opportunities to have a positive effect with interventions in those periods, particularly in pregnancy and early childhood. However, for a large segment of Kentucky's population, it is more likely the cumulative load of chronic stressors that leads to this flattened trajectory of health development. Economic stressors predominate, particularly in the Appalachian region. In Kentucky, 21% of people live in poverty, compared to 18.3% nationally. For KY children, nearly one in four live in poverty. Median

household income is 20% below the national rate. Unemployment has jumped from 6.6% in 2008 to over 10% in 2010; in some counties in eastern KY, unemployment is over 17%. . A ranking of state's economic distress puts KY at 48th [Kaiser]. The uninsured are 14.8% of KY's population, but due to the commitment of state policy makers, only 9.5% of KY's children are uninsured, which is better than the national average. The association between lower educational levels and chronic stress is well known. People with lower educational levels are less likely to be employed, to have adequate incomes, and to have health care access and coverage. Vital Statistics Birth Certificate Data from 2008 showed that 21.1% of Kentucky mothers had less than 12 years of education. Todd County in western KY has the highest percent of mothers with less than 12 years of education at 41.8%.

A major chronic stressor for Kentuckians is smoking. As one of the leading tobacco producers in the country, the prevalence of tobacco use in Kentucky is one of the highest in the nation. Nearly 1 in every 3 adult Kentuckians smoke, and the health impact (downward arrows) impacts rates of cancer, COPD, SIDS, Asthma, Cardiovascular disease, preterm birth, and many other morbidities. Teen smoking is now about 25%, and smoking in pregnancy is second highest in the nation at 28%. With the Life Course perspective, we can anticipate that the adverse effects of smoking, both physiologic and psychologic, are cumulative over the life course, and in indeed lead to a declining health status and premature death. Smoking rates are higher in those with lower socioeconomic and education levels, which only increased their risk and the likelihood of a lower health trajectory from cumulative effects.

The Life Course Perspective helps us to understand that stress should be measured not simply in terms of stressful life events, but also the chronic social stressors that are pervasive in the everyday lives of Kentuckians. In environments of geographic isolation, economic depression, educational underachievement, and high rates of tobacco use, the lower health trajectory of many Kentuckians is understandable. However, we can also use the Life Course model to develop better approaches to health for Kentuckians despite these chronic stressors.

Kentucky has presented the Life Course Perspective Health Development Model to partners, policy makers and legislators using our HANDS Home Visiting program as an example. The HANDS program began in 1998 and was intentionally designed as a strengths-based program. Home visitors work with high risk first time mothers or dads on not only general health and child development, but also on skills to build family self-sufficiency. These include caring relationships, problem solving, conflict resolution, ability to access resources, good mental and physical health -- the positive protective factors that build resilience and raise the trajectory of health status. Program evaluations show that participating families, compared to a similar group, have less preterm birth, less low birth weight infants, less substantiated child abuse and neglect, less emergency department utilization, improved education levels, improved employment, and improved family self-sufficiency. This is the Life Course model in action, working on the positive protective factors rather than trying to eliminate risk factors which are beyond our control. We do not raise these families out of poverty, move them to more affluent communities, nor make them into college graduates, but the program does give them skills to cope with their chronic stresses, and even in the short timeframe of a pregnancy, that can lead to improved birth outcomes.

The Life Course perspective provides a longitudinal account of the interplay of biologic, behavioral, psychological, and social protective and risk factors producing adverse health outcomes. Lu and Halfon posit that closing the gaps in disparate health trajectories will require" 1) closing the gap in one generation to give the next generation an equal start, 2) targeted interventions during sensitive developmental periods (e.g., in utero development, early childhood, puberty, pregnancy), and 3) risk reduction and health promotion strategies across the life span." Some of our programs that work towards these ends, through the life course, are as follows:

PRECONCEPTION
Preconception care has been recommended for more than a decade, but the Life Course perspective better explains why interventions only during pregnancy may not be the most

successful way to have healthy pregnancies. Women must be healthy before and after pregnancies. The Women's Health divison, described later, is taking the lead in enhancing "well woman" services and promoting preconception care.
Folic Acid Program: KY provides all women of childbearing age access to the B vitamin Folic Acid through local health departments. Consuming folic acid prior to becoming pregnant can prevent 50-70% of neural tube defects. According to the CDC the annual medical care and surgical costs for persons with spina bifida in the U.S. exceed $200 million, and the approximate lifetime cost for an infant born with spina bifida is $532,000 and for many children the cost may be well above $1,000,000. For the past six years the estimated annual cost to KY residents is 12.1 million dollars. The KY Folic Acid Program is part of the KIDS NOW initiative. Currently about 58,000 women of child-bearing age annually have received folic acid counseling and / or supplementation.
Family Planning (FP): The CDC's recommendations for preconception care start with planned pregnancies. The Family Planning Program provides FP services and referrals for smoking cessation, nutritional counseling, substance abuse counseling, and other preventive health programs. KY has a total of 173 FP clinic sites in all 120 counties for FY 10. All local health departments (LHD) provide FP services. KY FP clinics offer Limited English Proficiency (LEP) services through an onsite interpreter or a contracted interpretation phone service. FP clinics provide community outreach strategies through health fairs, newspaper advertisement, radio advertisement, services to counsel students on services within the schools, and pamphlets.

PERINATAL
Prenatal Program: The Title V program provides funding to local health departments in all 120 counties to assure prenatal care is available for low-income and uninsured individuals. Currently 17 health departments have in-house prenatal clinics, but most have been able to partner with local providers to assure care for pregnant women. Major prenatal health issues such as prematurity, smoking in pregnancy, domestic violence, postpartum depression, perinatal HIV transmission, and substance abuse in pregnancy are consistently addressed in the LHDs. DPH provides annual training and updates to LHD staff on current guidelines on prenatal care, including prematurity prevention and smoking cessation, Prenatal guidelines for LHDs are provided in the prenatal section of the Public Health Practice Reference and follow recommendations from ACOG and AAP.

Healthy Babies are Worth the Wait (HBWW): HBWW is an innovative approach to prematurity prevention that by design addresses themultiple determinants of preterm birth. It began as a partnership with March of Dimes and Johnson & Johnson and the KY Dept for Public Health in 2007, and now is being expanded to other sites. Community health leaders, including hospitals and health departments, work together with local March of Dimes to implement multiple interventions known to reduce preterm birth, and improve systems of care in their communities. Target audiences are health care providers, pregnant women, and the general public, as prematurity affects the entire community. The pilot involved 6 communities, three intervention sites and three comparison sites. Materials include a Community Toolkit for Prematurity Prevention, which provides handouts, talking points for different audiences, powerpoint presentation, and instructions on how to approach community partners. All materials are available on the web site, in English and Spanish, at www.prematurityprevention.org.

Fetal Infant Mortality Review (FIMR): Two fetal infant mortality review projects are currently underway in KY. One is in Louisville, which has the state's largest African American population, and the second in Bowling Green, KY, where there is a significant Hispanic population. The review teams in these areas will provide more accurate data on fetal and infant deaths along with the identification of risk factors and potential prevention strategies. System barriers that may influence infant mortality may be identified and addressed by the community team members.

Newborn Screening (NBS): Approximately 57,000 infants are born in KY each year. KY law mandates that all infants born in KY receive newborn metabolic screening. The Title V program has nurses who provide case management to assure patients and providers received adequate

information, contact is made between the University specialty clinics and the community medical home, and that short term and long term follow up testing is completed. The NBS collaborates with the State Public Health Laboratory, pediatric specialty clinics at UL, UK, Cincinnati Children's Hospital, and Vanderbilt University, primary care providers, LHDs, birthing hospitals, Medicaid, the HRSA Region 4 Genetics Collaborative, KY's NBS Task Force, CFR, the KY Birth Surveillance Registry (KBSR), the March of Dimes and the National Newborn Screening and Genetics Resource Center.

GIFTS (Giving Infants and Families Tobacco-free Starts) is a smoking cessation program, implemented in 2008 and designed to offer support, encouragement and education to pregnant mothers who smoke or are exposed to secondhand smoke. Based on the Life Course perspective, this program was developed to promote strengths and provide positive supports, as well as screening for domestic violence and depressions, two of the main stressors associated with smoking in women. The program is expanding to a total of 13 counties in Eastern KY and into the western half of the state's urban areas. The program is available to any pregnant women who smoke or have quit in the past 3 months and receive any service from the participating health department. The service offers each woman individualized time with a GIFTS supporter through face to face contact and additional support and education through telephone contacts or mailings. Contacts are adjusted by individual need and made through face to face meetings, health department appointments, home visits, telephone calls, emails, postcards and letters. Women are also screened and referred for domestic violence, depression, social support needs and secondhand smoke. GIFTS provide family members with education and referrals to Cooper Clayton classes and the Quit Line. The GIFTS website is available at www.mc.uky.edu/KYgifts and contains information and fact sheets.

EARLY CHILDHOOD

Women, Infants, and Children (WIC) Supplemental Nutrition Program

The federally funded WIC Program sets the standards for nutrition services. WIC's primary focus is to provide nutritious foods, nutrition education and, when appropriate, breastfeeding information and appropriate social and medical referrals for low-income pregnant, breastfeeding and postpartum women, infants, and children who are at nutritional risk. WIC is available in all 120 local health departments, and several health department satellite sites. WIC serves approximately 140,000 women, infants and children per month. The program is actively promoting breastfeeding. WIC has a breast feeding peer counselor support program in 14 sites across the state. WIC sponsors the state breastfeeding coalition and is developing the state plan for breastfeeding.

Health Access Nurturing Development Services (HANDS)

The HANDS program is a voluntary home visiting program for first time moms or dads who are identified with two or more risk factors on a screening tool. HANDS is available in all 120 counties through the local health departments, and works with community partners to assure they are aware of the program and make referrals when appropriate. HANDS will accept families referred any time during the pregnancy or up to 12 weeks after the baby is born. Professional staff do a comprehensive assessment of the family and family support workers who have been thoroughly trained with a curriculum then address the family's needs. Parent-child attachment and bonding, parenting practices, problem solving, resource management, and health education are all included. HANDS makes referrals to/for basic needs, child care, domestic violence, education, employment, First Steps, LHDs, mental health, oral health, physician care, smoking cessation, substance abuse and transportation. Local HANDS staff participate in community collaborative groups, with public and private partners.

KY's System to Enhance Early Development (KY SEED)

In October 2008, KY was awarded a six year cooperative agreement between the Substance Abuse and Mental Health Services Administration and the DBHDID to further KY's development of its system of care for children age birth to five who have social, emotional, and behavioral needs and their families. The vision of KY SEED is to facilitate the development of an integrated

system of care that supports young children and their families to thrive socially, emotionally, and behaviorally. The mission is to significantly improve coordination of, access to, and effectiveness of services. The State Implementation Team is composed of strong representation from Public Health including representation from the following MCH Programs: First Steps, HANDS, ECMH, and CCHC. Local Implementation teams have the same membership but local staff.

Early Childhood Mental Health (ECMH)
The ECMH Program is a program funded through KIDS NOW. The goal of the program is to support the social and emotional growth of KY's children birth to age five by emphasizing the importance of nurturing relationships in multiple settings. This program trains and funds early childhood mental health specialists in each of the Mental Health regions in the state. The services provided by the specialists include assessments, therapeutic services, training and resources for public and private providers. Additionally, the specialists provide and sponsor training and consultation to child care providers and fellow clinicians to assure high quality care and increase the number of qualified professionals serving these children. Approximately 400-500 children are served each year. The Collaborative partners include: KDE (Division of Early Childhood Development), Division of Child Care, local Community Early Childhood Councils, local Child Care Resource and Referral Agencies, State and Regional Interagency Councils (SIAC & RIAC), LHDs including programs like HANDS and CCHC, First Steps, KY Partnership for Families and Children, and KY SEED.

First Steps, KY's Early Intervention System (KEIS) is administered by the Cabinet for Health and Family Services and is mandated by the Federal Part C program to serve children from birth to age 3 with a developmental delay or a specific medical condition that is known to cause a developmental delay. First Steps services are voluntary and provided statewide by over 1,200 providers who are involved in direct service provision to children and families. Point of Entry sites in each region administer the program for their district; these include health departments and mental health centers. For 20 years, KY has delivered early intervention services to approximately 10,000 children each year.

Reach Out and Read (ROR)
ROR is funded by KIDS NOW, and works with pediatric health care providers including LHDs, pediatricians, and Family Practice providers to help raise pre-reading skills among young children of low income by educating parents about the value of reading to children. ROR provides developmentally appropriate books to take home at each pediatric visit from 6 months to 5 years. Sites must serve a significant number of impoverished children. Many sites are in located in LHD clinics, community health centers and other clinics serving children and families with Medicaid or who are uninsured. The KY ROR program serves over 37,000 children during their 75,000 Well Child visits and has provided over 65,000 books since December 2007.

KY Oral Health Program (KOHP)
The KOHP works to improve the oral status of all Kentuckians and houses programs that target that goal. The Community Fluoridation Program works with municipal and private water systems to assure compliance with KY's state-wide law that requires fluoridation at optimal levels to reduce decay rates in the state. KY has the highest rate of municipal system customers having optimally fluoridated water than any other state in the U.S.
KOHP supports LHDs for the provision of fluoride varnishes and dental sealants to their clinic- and school-based patients. Up-to-date training in dental development and disease prevention is provided to public health nurses throughout the state. KOPH has also collaborated with the KY Chapter of the AAP to train pediatricians and their nurses to provide fluoride varnish treatments, which are now reimbursable through Medicaid.
Through a contract, KOHP supports and partially funds preventive and restorative outreach services of UK's College of Dentistry to underserved children through their mobile dental vans and remote clinics/teaching sites.

The KOHP is in Year 3 of the four-year Targeted MCH Oral Health Service Systems (TOHSS)

Grant through HRSA. TOHSS's goals are supporting the expansion of preventive and restorative oral health services for Medicaid and State Children's Health Insurance Programs (SCHIP) eligible children and other underserved children and their families. The KOHP is partnering with the KY Division of Family Resource and Youth Services Centers (FRYSCs) and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs in the Cabinet for Health and Family Services and local health departments to assist with these efforts.

Developing community oral health coalitions will provide solutions to barriers regarding the lack of access to dental services. Sustainability of the coalitions lies in training on strategies to increase the awareness of oral health knowledge and advocacy skills to create social change towards oral health. Twenty-five community oral health coalitions have been provided seed funding. These coalitions are funded through grants from the federal Health Resources and Services Administration and the quasi-federal Appalachian Regional Commission.

To address access for children in rural areas, the KOHP is developing a training program that offers a general dentist practical training in pediatric techniques so that they will see this young patient population. This is funded by HRSA, yet receives an enhancement grant from ARC to target the dentists in the ARC geographic area to participate. This will increase access for children in need to dental care. The development group is using the Washington State ABCD program as a template of success for the training curriculum.

SCHOOL AGE CHILDREN

EPSDT / KCHIP Outreach

The KY Department for Medicaid Services (DMS) contracts with the DPH to provide funds to LHDs with facilities in all 120 KY counties to support clinical and community outreach for the EPSDT Program and participants. More than 360 LHD administrative, support and nursing staff provide EPSDT outreach services to families of eligible children statewide. Families are verbally notified of the value and necessity of EPSDT services by phone, written notice, home visits or during clinic visits for other health department services. These community EPSDT outreach workers encourage families of eligible children to obtain screening services through KenPac, community providers, and, if no community provider is preferred or designated by the family, help them make EPSDT appointments at LHDs if desired.

The EPSDT Program works with DMS, other public health programs (Lead, Oral Health, WIC, HANDs, Immunizations, Family Planning), the KDE and Passport Health Plan. LHDs maintain working relationships with county and city schools, local agencies of DCBS and health care practitioners who provide direct services to EPSDT participants.

DMS contracts with the DPH to provide funds for a statewide 800 number, a statewide TTY number and translation services. Additional funds were provided in FY 10 to Fayette County Health Department to conduct community grass roots outreach throughout the state. LHD EPSDT and HANDs programs throughout the state have partnered in FY 10 with the KCHIP Outreach programs in DPH and DMS to help meet the goal to increase Medicaid and KCHIP enrollment by 35,000 children through June 30, 2010. DMS and DPH has engaged LHDs and statewide providers through training opportunities to promote KCHIP enrollment as they conduct health care services among families of underinsured or uninsured children. Families are contacted by health departments face to face in clinic settings or by phone or home visit and presented with opportunities and assistance to complete KCHIP applications. Other partners and stakeholders include but are not limited to community schools, Family Resource and Youth Services Centers, and DCBS offices, as well as the United Way, the Hagar Foundation, Covering KY Kids and Families, KY Voices for Health, KY Youth Advocates, KY Council of Churches, Catholic Conference of KY, Louisville Jefferson County coalition and Passport Health Plan.

Child Fatality Review (CFR)

Child Fatality Review is critical to preventing injury and death to children in KY and combines the expertise of the local coroner, health department, DCBS, law enforcement, and other critical partners. By working as a team, these agencies gather information that may have otherwise been missed had the death not been reviewed. The local CFR team is critical in helping the

coroner determine the exact cause of death, ensuring that other children in the home are safe, making certain grief counseling and community resources are offered to the family, identifying factors that may affect other children, and ruling out intentional injury.
Prevention efforts such as the HANDS program, state and county SAFE KIDS coalitions, and CFR, address motor vehicle injury and child related deaths. MCH serves as the lead agency for the state SAFE KIDS coalition and provides technical support for chapters around the state. LHDs offer car seat checks, assist with train-the-trainer education for certified child passenger safety instructors, and partner with other agencies such as Drive Smart, the Governor's Highway Safety Program, the State Police, and the Transportation Cabinet.

Injury Prevention
DPH contracts with UK to administer the KY Injury Prevention Research Center (KIPRC). The Title V MCH Program provides funding for a pediatrician injury prevention specialist, who provides technical support the local health departments to develop child fatality review teams in order to reduce child injury and death across the state. Through KIPRC, deaths and serious injury are investigated and findings are used to develop practical public health initiatives through education, programming, policy initiatives, surveillance, risk analysis, direct interventions, and evaluation.
DPH also contracts with the Norton Regional Poison Control Center that provides 24-hour, seven day a week access to poison information for consumers and professionals. This contract also allows public and health professional education.

Coordinated School Health (CSH)
In KY, KDE and DPH are working together, along with many other state partners, to help children be healthy and ready to learn, to achieve and be successful productive citizens. KDE and DPH have developed a unique partnership through the funding of a CSH grant by the Centers for Disease Control and Prevention(CDC), Division of Adolescent School Health whereby staff from both departments work together as a team to coordinate school health policy and program efforts. This CSH Team helps school districts, local health departments and their community partners improve their school health programs by implementing "promising practices" as recommended by CDC. CSH consists of an eight-component model that recognizes how health, wellness, environment and learning are related. This national CDC CSH Eight Component Model is comprised of: health education, physical education/physical activity, health services, nutrition services, family and community involvement, staff wellness, healthy and safe school environment and counseling, psychological and social services. Promising practices include monitoring health-related behaviors, programs and policies. Data and evaluation sources include the administering of the KY Youth Risk Behavior Survey (YRBS), administering PROFILES (system of surveys assessing school health policies and programs in middle and high schools), School Level Impact Measures (SLIMS -- measures of the percentage of secondary schools in a jurisdiction implementing policies and practices recommended by CDC to address the critical health problems faced by youth), program process measures and success stories.

Well Child / School Health
Preventive well child health services to promote and safeguard the health and wellness of all children are provided though local health departments across the state. The university pediatric and obstetric programs also are contracted to provide expertise and trainings to the health department staff for the programs the state provides through the LHDs. Protocols for health department staff to follow for well child visits are in the Public Health Practice Reference and are aligned with Bright Futures and AAP Guidelines.
LHDs collaborate with local school boards for the provision of preventive health services in satellite clinics within the school setting, which promotes improved access to health information and preventive health services for school age children. School health services provided by LHD staff have increased significantly in the last 3 years and are now one of the leading services offered by health departments in their local communities.
University tertiary care centers provide evaluation and service planning for children ages three to 16 with developmental concerns. These services make available developmental experts in the

field of pediatric specialties and assure that KY children will have accessible services to identify, diagnose, and treat complex high risk conditions to prevent or minimize disabilities. Both the tertiary care centers provide various support services to families as well as professional guidance, consultation, and training to community physicians and other health care providers on the care and needs of these children.

Pediatric Obesity
Many collaborative efforts regarding pediatric obesity have been accomplished through MCH programs such as WIC and CSH (further described in the State Priorities Narrative). Capacity in this area has been improved. Both university pediatric programs have begun multidisciplinary clinics for obese children; the KY chapter of the American Academy of Pediatrics has several initiatives to train pediatricians to address obesity in their offices as a quality improvement activity; the Partnership for a Fit KY continues to work at the state and community level on environmental change. Policy makers are more aware of the issues and proposing things like mandatory physical activity in schools (not passed yet). The Title V program hopes to further advance these initiatives moving forward until we see a change in this adverse trend.

Childhood Lead Poisoning Prevention Program (CLPPP)
CLPPP offers a comprehensive approach to preventing lead poisoning in children less than six years of age. Statewide services provided by Medicaid's EPSDT and Well Child programs, the WIC program, and private providers assist CLPPP in identifying children with elevated blood lead levels. CLPPP collaborates with other state and LHD programs such as HANDS, Asthma Prevention, Environmental Lead, OSHA, EPSDT, and Prenatal. CLPPP provides health education to local communities by offering information and materials to provider associations including KY Medical Association, KY Pediatric Society, and KY Rural Health Association, as well as community health fairs and conferences. KY State Fair, where CLPPP distributes over 1000 pamphlets and "freebies" each year is, the largest outlet for educational information targeting parents and families. CLPPP is currently working with CDC to transition into a more holistic "Lead and Healthy Homes" program. This new program will integrate lead poisoning prevention with other programs focused on improving health outcomes by correcting housing issues. These programs will include but are not limited to Radon, Asthma Prevention, Injury Prevention, mold, and vector control.

ADOLESCENT/ ADULT

TEEN PREGNANCY
Both teen pregnancy rates and teen birth rates are typically higher in KY than national rates. Since 1999, the KY rate for teen pregnancy for teenagers 15 -- 17 years old has shown an overall downward trend. After a downward trend in preceding years, KY's teen birth rate for teenagers 15 -- 19 years old increased in 2006, from 47/1,000 in 2005 to 54/1,000. According to preliminary data, the 2009 teen birth rate is 52/1,000. In the Title V Needs Assessment, teen pregnancy was one of the leading concerns in communities across the state. Several health deparatments are involved in more intense efforts to address this issue.
The Little Sandy District Health Department (LSDHD), Grayson KY, has partnered with their local hospital to provide family planning services on high school campuses. King's Daughters Hospital is providing the mobile unit which is equipped to perform physical exams and provide privacy for counseling. LSDHD provides the clinical staff and supplies necessary to provide family planning services. The mobile LSDHD unit provides services one day a month at three high schools, two in Carter County and one in Elliott County, and average seeing 8-10 students each visit.
Technical assistance funding in the amount of $1,238 was awarded to the Division of Women's Health from MCHB for technical consultant Clint Thomas. Mr. Thomas provided technical assistance for teen pregnancy prevention and positive youth development at Kentucky's Teen Pregnancy Prevention Summit on May 10, 2010. Included was information on how to connect with adolescents and positive messages that encourage young people to think and be smart. He also provided avenues to show young people that the messages they receive from media is deceptive, and how to help them make good choices. The TA provided the attendees (health

educators, school educators, youth workers) with a renewed interest in the students with whom they work and a feeling of empowerment to make a difference in the lives of the teens of Kentucky.

YOUNG PARENTS PROGRAM (YPP)
The Adolescent Health specialist at University of Kentucky is funded by the DPH Divisions of Women's Health and MCH to provide comprehensive services for first time parents and pediatric services to their infants and reports the outcomes of their patients to the DPH, MCH Division. The YPP provides comprehensive medical and psychosocial services to adolescents who begin prenatal care at the KY Clinic Obstetrics Clinic prior to their nineteenth birthday. Services include: prenatal, postpartum, and child development assessments. YPP provides family planning services to teens and male reproductive health services for pregnancy and STD prevention, along with other preventive services, and reports the outcomes to the DPH Division of WH. The YPP YPP provides comprehensive sexual education, including abstinence, at mutlitple school sites The YPP reduced the repeat teen pregnancy rate to less than 1% of teens in the program. The YPP provides a statewide conference on "Stop Youth Suicide Campaign" as well as training for UK's OB/GYN and Pediatric medical students and residents. and provides clinical family planning services at the UK Adolescent Clinic.

SUICIDE PREVENTION
KY Department for Behavioral Health, Developmental and Intellectual Disabilities Substance Abuse (KDBHDIDS) Suicide Prevention personnel serve as support to KY Suicide Prevention Group, including assistance with public relations and Presentation workshops, advocacy workshops, suicide survivor conferences and other survivor supports and resources, State Fair booth -- manning and other assistance as needed, basic monthly meeting and additional support as needed. KDBHDIDS Suicide Prevention personnel serve as coordinator of QPR (Question, Persuade, and Refer) trainers, including trainer certification trainings, scheduling trainings, trainer recertification, etc. There are currently around 150 active QPR trainers in KY. Suicide prevention members attend DPH's CFR state meetings likewise DPH staff members attend suicide prevention meetings and activities.

HIV / AIDS
This education, counseling and testing program is responsible for the development and monitoring of all counseling and testing sites across the state. All county health departments and many other professional agencies offer free anonymous or confidential HIV tests. The KY HIV/AIDS Services Program is funded through the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The Ryan White Part B Program was created to address health care and service needs of people living with HIV/AIDS. The Care Coordinator Program helps provide appropriate quality care and services in a timely manner to people living with HIV/AIDS. The goal of the program is to help program participants become self-sufficient.

STD PROGRAMS
STD services are provided at local health departments across the state. The primary goal of the KY Sexually Transmitted Disease/Human Immunodeficiency Virus Counseling and Testing (STD/HIVCT) program is to prevent the spread and resulting effects of sexually transmitted diseases, including HIV infection.

WOMEN'S CANCER SCREENING PROGRAM
The KY Women's Cancer Screening Program of DPH provides breast and cervical screening and follow-up services, professional education, public education, outreach, quality assurance and surveillance. Screening and follow-up services are provided from local health care providers through contracts with LHDs. The program is funded by both state and federal funds and is part of the National Breast and Cervical Cancer Early Detection Program.

ACCESS TO CARE
Local Health Departments serve as part of the healthcare safety net for those who do not have

public or private insurance coverage or the resources to pay. Title V funding to all local health departments supports these services in part. However, there are other safety net providers for primary health care, including FQHC's and Primary Care centers.
KY's predominately rural areas contain almost 50% of KY's population and 98 of its 120 counties are non-metropolitan making successful health care recruitment to this population particularly important for the health of the state. Access issues are still a problem for many families due to poverty, transportation issues and cultural isolation. Of the 120 counties in KY, most of the Health Professional Shortage Areas (HPSA's) are based on the county as the service area. Only thirteen of KY's 120 do not have either a HPSA (of any discipline) or Medically Underserved Area/Population designation. Currently there are 87 counties designated wholly or partially a Medically Underserved Area or Population. 63 counties are designated, wholly or in part, an Area or Population HPSA. 79 of our 120 counties are Mental Health Professional Shortage Areas, and 20 counties are currently designated Dental HPSA. The shortage area designations provide the counties with an opportunity for better recruitment and retention of providers through programs such as the National Health Service Corps and J1 Visa Waiver Programs. The designations also enable the county to participate in Rural Health Clinic Programs and Federally Qualified Health Center (FQHC) Programs that serve the low income and uninsured.
The KY Primary Care Association is a private, non-profit corporation of community health centers, rural health clinics, primary care centers and other organizations and individuals concerned about access to health care services for the state's underserved rural and urban populations. There are currently 18 Section 330 Health Centers operating in KY that receive funding to help offset some of the cost for providing health care to low income uninsured patients. These have approximately 58 service locations including a mobile van in 35 underserved counties of the state. The importance of primary care is more widely recognized and primary care centers cover all of the life stages - prenatal, pediatric, adolescent, adult and geriatric. In addition to offering primary care services, other services offered at these locations include: Dental, Mental Health/Substance Abuse, OB/GYN, Pharmacy, Other Professional Services and Specialty Care. In 2005, 224,183 individuals received services in the primary care centers. Three centers focus their services toward the homeless and seasonal/migrants farm workers.

The UK Center for Excellence in Rural Health in Hazard is one of the FQHC's and was established in 1990 to address health disparities in rural KY, including a chronic shortage of health professionals and residents' poor health status. The center accomplishes this through health professions education, health policy research, health care service and community engagement. Nearly 80 percent of the center's graduates are practicing in rural areas, most of them in KY. The center houses the North Fork Valley Community Health Center, the host clinic for the East KY Family Medicine Residency Program. The center also houses the KY Homeplace program and KY State Office of Rural Health, which are nationally recognized for improving rural residents' access to health care.
MCH's Oral Health Program partially funds and supports UK's College of Dentistry Outreach Dental Program in their Public Health Dentistry Department. This funding allows UKCD to take preventive and restorative services to the more underserved areas of KY through their mobile dental vans and their free-standing clinics in Madisonville, Hazard, and Morehead.
The UK College of Medicine began a The Rural Physicians Leadership track to train medical students to work in rural communities.Students spend 2 years at the medical college in Lexington and 2 years at Morehead State University in Eastern KY. In addition to the medical school curriculum, students learn other business skills needed to establish a medical practice in a rural setting. In addition, the UK College of Medicine has partnered with the UK Dental School to develop a network of rural centers for a translational research network, enhancing the capacity and access to dental care and other services in areas where there is little available. University of Louisville has partnered with Trover Clinic in western KY and offers medical students in the third and fourth year clinical rotations in a rural program. Both universities are funded from DPH for Area Health Education Centers, which provide health education for providers, and assist in placing students with private providers for rural health rotations.

HEALTH DISPARITIES

The KY Office of Health Equity (KY OHE) was established in September 2008, operating through the DPH Commissioner's Office. Funding from the U.S. Department of Health and Human Services (US DHHS), Office of Minority Health (OMH) supports KY OHE. The office was created to address health disparities among racial and ethnic minorities, and rural Appalachian populations. Specifically, KY OHE seeks to create opportunities for health equity relating to infant mortality and preconception care as well as chronic diseases such as cancer, diabetes, heart disease, and HIV.

The overarching goals of the KY OHE are as follows: build the state's infrastructure to address the elimination of health disparities through strategic planning, data collection, and program evaluation; train and develop a culturally competent public health workforce across the state of KY; disseminate culturally and linguistically appropriate products, health programs and health services; enhance community capacity to develop health equity; support policies for the elimination of health disparities.

The KY OHE supports a wide variety of activities and services including promoting effective partnerships with local universities, non-profit organizations, and private health systems. Since 2008, KY OHE has formed official partnerships with many agencies to continue to strengthen prevention in relation to minority health.

The Jefferson County Infant Mortality Project was developed in collaboration with the Center for Health Equity, based out of the Louisville Metro Department of Public Health and Wellness with the purpose to determine the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American women in urban communities of Jefferson County. Focus groups were conducted and the results are being analyzed. The Louisville Metro Health Department (LMHD) Healthy Start (HS) Program continues to be federally funded and is an initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes through grants to areas with high annual rates of infant mortality.

The Bluegrass Farm worker Health Clinic (BFHC) continues to provide services to the ever growing Hispanic population of seasonal migrant workers. The Center consists of two facilities to serve migrant and seasonal farm workers in Madison, Fayette, Garrard, Jessamine, Woodford, Bourbon, Clark and Scott counties. All staff members are bilingual. The Center also provides preventative care, such as family planning, TB screenings and blood pressure checks, and health education.

COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CCSHCN)

The CCSHCN has a long history dating back to 1924 when it was created by the State Legislature in response to a request from the Rotary Club to provide treatment to children with orthopedic conditions through itinerant clinics across the state. The focus on community-based systems of care continues today. In addition to being a direct services provider, CCSHCN has assumed a leadership role in assuring state and local systems of care for children and youth with special health care needs (CYSHCN) and in promoting a broader definition of health for CYSHCN and their families as defined by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The CCSHCN has a strong commitment to the inclusion of families and family support. This was acknowledged and enhanced in 2009, when CCSHCN was awarded the Family to Family Grant Health Information Center grant, which will provide for developing family partnerships throughout the state, so families may act as mentors for each other. As a national leader in developing systems to support the transition of CYSHCN to adulthood, Kentucky became the first state to develop a Title V performance measure for transition to adulthood in 1997. This initiative has continued to be an area of growth and continues to evolve to meet the needs of our children beginning at enrollment, regardless of age.

Kentucky began providing medical consultative support for medically fragile foster children and their families which allowed CCSHCN to assess the needs of a growing population of at risk children. CCSHCN provides nurse consultants to the child welfare system. These nursesare housed in DCBS offices, make visits to all child welfare offices, and provide case-specific consultation for children in the program.

CCSHCN continues to focus on the expanded need to serve children statewide, including an increased emphasis on population-based services. The Kentucky Early Hearing Detection and Intervention (EHDI) program consistently reports the screening of over 99% of Kentucky newborns with referrals for diagnostic screening given to all children reported to have a risk factor for hearing loss. The program is currently focused on obtaining the follow-up diagnostic testing results for the newborns who have been identified as at-risk for hearing loss.

B. Agency Capacity

Assurance for the Health of Kentucky's Women, Infants and Children

Capacity - Policy

Governor Steve Beshear and the First Lady have been actively promoting child health in Kentucky. Together with statewide providers, DPH supported the Governor's initiative by working to help increase the enrollment of eligible families in KCHIP and Medicaid by more than 41,795 children by April 2010, exceeding 19% the original target of adding 35,000 children. Local health departments identify potentially eligible families and partner with community providers, schools and agencies to offer families help with a streamlined enrollment process. In addition, the Governor has established two Task Forces. The Task Force on Early Childhood Education and Care is reviewing the state's current early childhood programs and will make recommendations to enhance or expand them, or identify gaps to fill. The Task Force on Philanthropy is to focus the state's philanthropic groups on a few worthy causes that could have more impact with a combined effort of support. MCH programs have been presented to both groups and were well received. The Governor has also adopted Children's Oral Health as one of his initiatives, and toured the state with the State Dental Director announcing the HRSA Oral Health Grant and the awarding of the 24 Oral Health Coalitions through grant funding.

In the 2000 Kentucky Legislative Session, the "KIDS NOW" Early Childhood Development Authority was created to administer tobacco settlement money to support programs for children from the prenatal period through age 5. This program added $25 million to early childhood programs, as well as a system of accountability and collaboration for early childhood systems in Kentucky. Although receipts from the Master Tobacco Settlement are down from decreased tobacco sales, Kentucky has maintained their commitment to dedicate this portion of MTS dollars to invest in children. The Kentucky Medicaid program has also maintained its commitment to Kentucky's women and children despite challenging financial times. Eligibility for services for pregnant women and children remains at a high level and eligibility and enrollment have not been curtailed as a cost-cutting strategy. The commitment to KCHIP also remains firm.

A number of public-private partnerships and foundations work to explore and address health policy issues in Kentucky. These include the Kentucky Institute of Medicine, based at the University of Kentucky, the Foundation for a Healthy Kentucky, The Freidel Committee for Health Care Transformation, and the Child Healthy Policy Center at Cincinnati Children's Hospital. Professional organizations, especially the KY AAP, KY ACOG, and the Kentucky Medical Association, are actively involved in health care policy development. The Kentucky Public Health Association and Kentucky Health Department Director's Association develop policy statements specifically around public health in the state.

Capacity - Kentucky Statutes
State statutes relevant to Title V programs are listed below and may be viewed in their entirety at http://lrc.ky.gov.

Perinatal & Women's Health

KRS 194A.095 Directs that an Office of Women's Health be established within the Cabinet for Health and Family Services.

KRS 214.160 Requires syphilis testing for pregnant women.

KRS 211.651 -- KRS 211.670 Authorizes the Birth Surveillance Registry administered by the Division of Adult and Child Health Improvement. Allows Birth Surveillance Registry personnel to review and receive records from medical laboratories and general acute-care hospital if voluntarily participating in keeping a listing of both inpatients and outpatients.

KRS 214.155 Authorizes newborn screening for inborn errors of metabolism and other hereditary disorders. This regulation is currently being revised to reflect the expanded newborn screening legislation that was passed in the 2005 Kentucky General Assembly.

KRS 304.17A-139 Provides for a $ 25,000 cap on coverage for inherited metabolic diseases nonmedical formulas and a separate cap of $ 4,000 on low-protein modified foods for each plan year.

KRS 311.6526 Requires guidelines for responding to abandoned infants, including preserving the confidentiality of the parent, and define "newborn infant" as an infant less than seventy-two (72) hours old. Providing implied consent for treatment and confidentiality for the person releasing the infant with the provision unless indicators of child abuse or neglect are present.

HB 108 AN ACT relating to the protection of unborn children. Created a new section of KRS Chapter 507 to include unborn child after viability within the definition of "person" for the purposes of the criminal homicide statues to criminalize fetal homicide; create a new section of KRS Chapter 532 to provide a sentence enhancement for criminally causing a miscarriage or still birth of a fetus before viability.

Pediatric

KRS 156.501 Established a full-time position of education school nurse consultant within the Department of Education and specify employment requirements and job duties to include development of protocols for health procedures, quality improvement measures for schools and local health departments and data collection and reporting.

KRS 200.650-KRS 200.676 Kentucky Early Intervention System/ First Steps.

KRS 211.680 Authorizes the Department for Public Health to coordinate efforts to reduce the number of child fatalities through reviews of unexpected child deaths.

KRS 211.900 - KRS 211.905 Authorizes comprehensive lead poisoning prevention services.

KRS 213.410 - Authorizes SIDS services.

KRS 214.034 - KRS 214.036 Establishes immunization requirements for children.

KRS 214.185 Permits diagnosis and treatment of minors for contraception, sexually transmitted diseases and pregnancy related care without parental consent.

KRS Chapter 95A.200 Establishes a Safety Education Fund to be administered by the Commission on Fire Protection Personnel Standards and Education to initiate education programs in the public schools and other agencies to reduce and prevent injuries and loss of life.

Children with Special Health Care Needs

KRS 194A.030(7) Creates the Commission for Children with Special Health Care Needs

KRS 200.460 - KRS 200.499 Commission for Children with Special Health Care Needs. Establishes the organization and guidelines for providing services to children with special health care needs.

KRS 200.550 - KRS 200.560 Provides for the detection and treatment of children and adults with bleeding disorders.

KRS 211.645, 211.647 and 216.2970 Universal Newborn Hearing Screening.

KRS 213.046 When a birth certificate is filed for any birth that occurred outside an institution, the Cabinet for Health and Family Services shall forward information regarding the need for an auditory screening for an infant and a list of options available for obtaining an auditory screening for an infant.
911 KAR 1:070. (Formerly 902 KAR 4:070) Implements the services of the Commission for Children with Special Health Care Needs.

MCH General

KRS 211.180 Gives the Department for Public Health the responsibility for public health, including improving the health of mothers, infants and children.

HB 67 Allows ARNPs and RNS to distribute nonscheduled legend drugs from a Department for Public Health approved list in local health departments.

2010 Legislation

Five bills passed both legislative chambers and have been signed into law by Governor Beshear, in 2010 that have particular relevance for our maternal and child health population.

HB 51 Requires the Cabinet for Health and Family Services to post suicide prevention awareness and training information on its Web page by August 1, 2010. It also requires every public middle and high school administrator to disseminate suicide prevention awareness information to all middle and high school students by September 1, 2010, and September 1 of each year thereafter.

HB 159 Establishes new sections related to the practice of applied behavior analysis. Key features of the law include establishment of a license for applied behavior analysis practitioners and coverage by insurance for applied behavior analysis services for individuals with autism spectrum disorders. While mandated insurance coverage is substantial, there is little impact on the First Steps Program as this law specifies that applied behavior analysis services do not replace or otherwise affect the obligation to provide services under an individualized service plan. Insurance coverage for these services is in addition to services entitled under a publicly funded program.

HB 179 Includes revisions to the Dental Practice Act that will increase dental services in Kentucky's local health departments. The "Public Health Dental Hygienist" is a newly established category of hygiene licensure that limits the employment of this professional to public health but

expands the scope of services they can provide without the presence of a licensed dentist. The new scope of practice includes the services now being provided by our public health nurses, but will now also include the placement of dental sealants.

HB 285 Is intended to help law enforcement officers, health care professionals, inmates, day care workers, and others who work with children to improve their abilities to spot signs of pediatric abusive head trauma.

HB 415 Includes provisions to prohibit text messaging, instant messaging, and e-mailing while operating a motor vehicle. It also prohibits cell phone use while driving if the driver is under eighteen years of age.

Capacity - Division of Maternal & Child Health (MCH)

The Division of MCH oversees the implementation of public health services to MCH populations in all levels of the MCH pyramid. MCH program collaborations with other state agencies is described in Section E. MCH epidemiologist and SSDI coordinator are at the division office level and epi capacity is imbedded in each of the branches. The division is comprised of three branches; Early Childhood Development, Nutrition Services, and Child & Family Health Improvement.

Early Childhood Development (ECD) Branch
The ECD Branch provides active leadership in achieving the health goals of the state's early childhood initiatives and implements statewide services for preventive health in very young children, education to the caretakers of those very young children and direct interventions for the children identified as needing developmental and/or social and emotional services. This branch promotes coordination and collaboration between the three major-birth-to-age-three programs in the state for both children with and without developmental concerns.

ECD Branch has a health policy specialist who provides epidemiology support, and three program sections: Early Childhood Promotion, Early Childhood Intervention, and Newborn Screening & Genetics Services. The Early Childhood Promotion Section includes the the Early Childhood Comprehensive Systems HRSA grant and three initiatives that were created in regulation by the early childhood legislation, KIDS NOW: HANDS, Childcare Health Consultation, and Early Childhood Mental Health. The Early Childhood Intervention Section includes the First Steps program, Kentucky's Early Intervention System (Part C) for children birth to age three who have developmental delay. The Part C program serves about 11,000 children annually. The Newborn Screening & Genetics Services section is home for the Newborn Metabolic Screening Program, Metabolic Foods and Formula program, Genetics Services and the Kentucky Birth Surveillance Registry.

Child and Family Health Improvement Branch (CFHI)
This branch administers the Title V MCH Block Grant, and also contains many of the traditional MCH programs, with three main sections: Perinatal Health, the Oral Health Section and the Pediatric Section. The Perinatal section oversees the Prenatal Program, FIMR, and the KY Folic Acid Partnership. The Pediatrics Section includes child preventive health screenings (Well Child and EPSDT), School Health, Child Lead Poisoning Prevention, Child Fatality Review and Injury Prevention program, the Coordinated School Health Initiatives, and EPSDT & KCHIP Outreach. CFHI assures quality programs in all areas of MCH programming and policy through coordination, collaboration and technical assistance to partners throughout the state.

The Oral Health Section works continuously to make medical professionals as well as nonprofessionals aware of the linkages of oral health with general health (i.e., diabetes, heart disease, preterm low birth weight babies, early childhood caries, and others) through disease prevention and health promotion activities including fluoride varnish, dental sealants, surveillance, and mobile dental clinics. The vision is that oral health is integral to general health and most oral

diseases are highly preventable using evidence-based approaches. Oral Health initiatives also target pregnant women and the links to preterm birth.

Nutrition Services Branch (NS)
The NS Branch includes the Nutrition Program, WIC Program, Breastfeeding Peer Counselor Program, and the WIC Farmers' Market Nutrition Program (FMNP), and the WIC EBT project. The federally funded WIC Program sets the standards for nutrition services. KY WIC serves about 145,000 clients per month. The program is also responsible for promoting breastfeeding.

The NS branch administers the WIC Farmers' Market Nutrition Program (FMNP). WIC FMNP provides participants in the WIC Program with food instruments/checks to purchase fresh fruits and vegetables at local farmers' markets. Fifty- two (52) local agencies/sites, approximately 14,332 WIC participants and approximately 600 farmers received the benefits of this Program.

The Medical Nutrition Therapy program provides medical nutrition therapy to eligible clients in 120 counties and community nutrition education services to all counties. Each local health department must assure the services of a Registered Dietitian for referring clients who need medical nutrition therapy. Besides providing medical nutrition therapy to patients with problems such as obesity, diabetes and cardiovascular disease, nutritionists conduct in-service education for staff.

The Kentucky WIC program has been innovative in moving to electronic formats for everything from vendor management to the breastfeeding peer counselors tracking and reporting. The WIC Program has received over $5.2 million for the development and piloting of an on-line, integrated EBT system. This system is currently operational in 10 counties and upon FNS approval will begin statewide rollout this year.

Capacity: Division of Women's Health

This Division of Women's Heatlh was created in a reorganization of DPH in 2008. Dr. Connie White, and obstetrician-gynecologist and current president of KY ACOG, serves as the Division Director. This Division focuses on promotion of women's health, as well as clinical services and prevention education. Programs include the Women's Breast and Cervical Cancer program, Title X / Family Planning services including Folic Acid supplementation and counseling and Sexual Violence Prevention and Education program, Adolescent Health, Abstinence and pregnancy prevention and Positive Youth Development programs. The Division is responsible for the Sexual Assault Prevention and Education Grant, partnering with the Dept for Community Based Services for its implementation. The Kentucky's Women's Cancer Screening program is one of few in the country that has met all of the CDC's 11 data indicators for the program consistently for 6 quarters. The program continues intensive outreach to women who are rarely or never screened. The division controls the Breast Cancer Trust Fund, a legislated fund for education, outreach, and research for breast cancer through sale of a breast cancer license plate and from a check-off on the Kentucky income tax forms.The Division is also working collaboratively with the Kentucky Commission on Women.

Capacity: Local Health Departments

LHDs are the primary service arm of the DPH MCH programs in communities across the state. Local health departments provide services in all 120 counties of the state, and are administered through 16 district health departments and 41 independent health departments. LHDs employ nearly 3700 of the MCH workforce. The majority of the Title V block grant funding, after the 34.9% that goes to CCYSHCN, goes out to the local health departments in an allocation proportional to the services they are delivering. Fund is restricted to specific MCH cost centers, but each health department can distribute their funding across those cost centers according to local needs. Standards of care are assured through DPH guidance documents, the Administrative Reference and the Public Health Practice Reference. State program staff provide

oversight through trainings, quality assurance, technical assistance, and monitoring of service and billing data. Detailed elsewhere, health departments promote coordination and collaboration in their communities through outreach efforts to patients, medical homes, and other community providers, as well as participation in community partnerships such as Early Childhood Councils, District Early Intervention Committees, Partnership for a Fit Kentucky local coalitions, Oral health coalitions, Site-based school councils, Coordinated School Health, and other community-based groups. Locally and at the state level, health departments often collaborate with County Extension Agents on health education topics.

Capacity: Universities.

The MCH Program provides direct services and population based services thru the two state University Medical Centers that have comprehensive Pediatric and Women's Health programs, the University of Kentucky and University of Louisville. Through contracts with the universities, the MCH program assures subspecialty care, including Genetics, Metabolic, Developmental, and Neonatal follow up services, are available across the state. This is still for the most part accomplished through regional clinics, but alternative approaches such as telemedicine are being developed for those uses where it is appropriate. Both University medical centers provide a full range of maternal and pediatric medical and surgical subspecialists who are available for consultation with providers in local communities, and provide transport of complex patients to the universities from out in the state when necessary.

Capacity: Commission for Children with Special Health Care Needs

Despite challenging economic times, the Commission maintains a strong commitment to enhancing the quality of life for Kentucky's children with special health care needs through direct service, leadership, education and collaboration. Through 12 regional offices throughout the state, direct medical services are provided to children with defined medical conditions, both congenital and acquired. Locations of regional offices and list of conditions treated by CCSHCN can be found at: http://chfs.ky.gov/ccshcn. Through a diversity of staff (nurses, therapists, nutritionist, transition coordinator, social workers, medical director, audiologists, parent liaisons, for example), CCSHCN provides family-centered, community-based care by sending treatment teams including nurses and pediatric specialty physicians to clinic sites throughout the state. Clinics for specific complex conditions that require multi-disciplinary treatment teams are held only in Bowling Green, Louisville and Lexington due to availability of providers. Throughout the state, alignment with universities and partnerships with other agencies (e.g. Shriner's hospitals) support access-to-care issues, lend capacity to the agency, and promote non-duplication of services. Families in need receive financial support to assist with travel and/or lodging in order to attend clinics or receive hospital services. A Memorandum of Agreement between CCSHCN and the State Division of Disability Services assures that children who apply for SSI benefits receive referral and outreach services.

CCSHCN maintains a local provider network through contracts with approximately 589 contract physicians and surgeons (including 142 dentists). Other medical and ancillary services e.g., therapists, pharmacists, audiologists are available through contracts with local community providers. CCSHCN also contracts with foreign and sign-language interpretative services to assure effective communication that is easily understood by families of diverse cultures including those with hearing impairments. These services are available in each Commission region. A need for interpretative services is identified during intake and arrangements are made for appropriate service prior to clinic or other Commission appointments. CCSHCN has a Memorandum of Agreement with the University of Kentucky to operate and staff a Medical Home for Coordinated Pediatrics, designed to provide primary health care and other services to the foster care population. This grew out of a need identified from a
CCSHCN Memorandum of Understanding with the Department for Community Based Services (DCBS) to provide nursing consultative services to children in the foster care system. Consultation to the DCBS social workers and foster care families includes discussion of medical

issues, interpreting medical records and reports, assuring updated medical passports and enhancing care coordination of all services to improve health outcomes for this population.

CCSHCN supports and encourages process improvement with the recommendations of parents of and children and youth with special health care needs. In addition to two parent consultants who are on staff, the agency coordinates a Youth Advisory Council and provides an opportunity for children and youth with special health care needs to collaborate with other youth, discuss pertinent issues, express needs to CCSHCN staff and become empowered in the management of their own health care. As well, the Parent Advisory Council and provides the same opportunity for parents of children and youth with special health care needs. Council members are provided financial support with their travel, meals, and lodging.

In 2009, CCSHCN received a Family to Family Health Information Center (F2F) grant. This funding provides parent consultants the ability to coordinate family partnerships throughout the state. Although the partnerships will be voluntary, CCSHCN will provide financial support with travel, childcare, meals, and lodging as needed. This new family mentor-matching program will provide a gateway for information-sharing between families, and will allow them to maximize their existing community resources. CCSHCN also received a grant for the Kentucky Infants Sound Start initiative to support the same, as well as support for the Kentucky chapter of Hands and Voices -- an organization for families and children who are deaf or hard of hearing.

CCSHCN continues to expand the capacity of its health information system to fully support the core functions of public health as relates to children and youth with special health care needs (CYSHCN): to assure early identification and screening leading to diagnosis, treatment, and access to community-based systems of care; to provide comprehensive care coordination with the context of the medical home; to identify and eliminate disparities in health status outcomes; and to support program accountability through the collection, analysis, and reporting of data and progress in meeting performance targets. The electronic patient data collection system (CUP) allows staff to enter patient information directly into a system designed to serve as an electronic medical record. Information pertaining to the demographic, diagnostic, treatment, medication, insurance, and transition history for each patient is maintained in a password-protected system on a secure network. This system is designed with future expansion and accommodation of agency needs in mind. Most recently, enhancements were made which enable audiological follow-up results to be electronically transferred, whereas, in the past, agency staff was manually entering each submitted follow-up report. This will improve the collection of follow-up audiological information; thus reducing the number of children who are lost to follow-up.

CCSHCN is experiencing an expansion of audiology services, and is becoming the preferred pediatric audiology specialist in the state. CCSHCN has more pediatric audiologists than any other public or private agency, provides technical assistance to and participates in partnerships with school systems, serves as a state and national consultant on EHDI issues, and is moving towards cochlear implant support services due to the absence of other providers in this arena.

Capacity: MCH Data Analysis and surveillance

Kentucky's capacity for MCH epidemiologic assessment has increased substantially in the past five years by additional staff with analytic and/or epidemiologic skills. With Tracey Jewell as the senior epidemiologist for the Division of Maternal and Child Health and Joyce Robl as SSDI Administrator and MCH Program Evaluator, other programs with epidemiologic support include Newborn Screening, the Kentucky Birth Surveillance Registry, Oral Health, Childhood Lead, and Child Fatality Review. The MCH epidemiology team meets monthly with the MCH Director to review projects and improve approaches to data collection and analysis.

State Systems Development Initiative (SSDI):
Kentucky is currently in year four of a five year SSDI grant period. This grant has two major goals: 1) To increase collaboration and data capacity within DPH through data linkages and data

integration of selected early childhood programs; and 2) To increase maternal and child health epidemiologic and health informatics capacity within the Division of MCH for the purpose of improved surveillance and analysis of selected early childhood outcomes as well as program evaluation. Efforts in the current year have focused on the title V needs assessment, the PRAMS survey and establishing linked birth and death files. The linkage of birth and death files was accomplished using Business Objects. Unmatched files were manually reviewed using potential matches generated by Business Objects. Linked files are available from 2006 through 2009. 2008 and 2009 data is preliminary as the files have not yet been closed by Vital Statistics.

Utilizing funding provided by the State System Development Grant, Dr. Arne Bathke, a statistician from the University of Kentucky has also completed two trainings for MCH epidemiologists and data analysts. These trainings have been very well received and participants have commented on a major strength of these trainings being the ability to focus on MCH related topics and the use of actual MCH data. The two trainings that were completed were on survival analysis and regression with a focus on logistic regression.

AMCHP Data Mini-grant (2009)Training provided two days of training on cost benefit and cost effectiveness analyses, using data from our home visiting program, HANDS. Part one of the training was completed on April 13, 2009, and part two on May 6, 2009. Eighteen individuals participated in day one of the training, with most participants returning for day two activities. The trainings were completed by Dr. Scott Hankins. Dr. Hankins is an Assistant Professor with the College of Public Health at the University of Kentucky. He holds a Ph.D. in Economics from the University of Florida. His research investigates factors that affect neonatal health. He currently is studying the effect of state regulations (both insurance and hospitals) on neonatal health outcomes. He also is interested in how obstetricians respond to medical malpractice lawsuits.

Pregnancy Risk Associated Monitoring System (PRAMS):
Kentucky is not yet funded by CDC as a PRAMS state, but has been able, through March of Dimes Grant funding and a collaboration with the UK College of Public Health Repreductive Epidemology professors, complete PRAMS pilot surveys in 2008 and 2010. The report of the initial pilot is available at http://chfs.ky.gov/dph/mch/default.htm under Related Links. The collection of 2010 data just ended in the spring, and the data is currently being weighted prior to analysis.

Capacity -- MCH Workforce Development

UK Graduate Certificate in MCH: Kentucky is a state with many maternal and child health problems, but until recently, had no training programs that focused on public health expertise in maternal and child health. DPH contracted with the College of Public Health to develop and administer the MCH Certificate to increase Kentucky's capacity to address MCH performance and outcome measures. The initial goal is to set up a certificate program for current public health professionals who are working in or interested in furthering their knowledge of MCH. The MCH Graduate Certificate has two main objectives: 1) To prepare public health workers to address the multi-factorial MCH issues in Kentucky in their workplaces by enhancing public health-related skills. 2) To provide participants with theoretical, practical, and relevant educational experiences in MCH to enhance the health and welfare of children, mothers and families. The program began in fall of 2009 and graduated its first student in June, 2010. More information about the certificate program can be obtained at http://www.mc.uky.edu/ publichealth/ certificateprograms.html.

MCH Epidemiology Graduate Certificate: In 2009, the University of Arizona (PI) and University of Kentucky Colleges of Public Health were awarded a $900K HRSA MCH training grant over five years to develop and implement a Graduate Certificate in MCH Epidemiology. The purpose of this project is to provide graduate-level MCH Epidemiology education to students serving rural and American Indian/Alaskan Native populations who would otherwise be unable to access continuing education. Course content is delivered using the internet. Fifteen students from across the nation are enrolled including three students from rural Eastern Kentucky HDs and one

dentist from the UK Center for Rural Health in Hazard (KY). Ten students will receive full scholarships annually and academic credits earned will be transferable for this program which is supported by HRSA T04MC16880 from the MCH Bureau, Health Resources and Services Administration. More information about this project is available at: http://mch-epitraining.arizona.edu/default.aspx or by contacting Lorie Wayne Chesnut, University of Kentucky College of Public Health at 859-218-2226.

Capacity -- Cultural Competence

The Cabinet for Health and Family Services which includes both DPH and the CCSHCN requires that services to clients be delivered in a culturally competent and family centered manner. Demographic data for all programs is collected so that different cultural groups can be analyzed to inform program and policy development.
LHDs receive guidance to understand and address barriers to cultural differences through the Administrative Reference guide provided by DPH. Procedures are included for interpretive services and direct-care workers. Culturally isolated are included in the target populations within the state. Materials for public health programs are made available routinely in English and Spanish, as 95% of our families who need interpreters are Spanish-speaking, but other languages are available if needed. Direct service programs, such as First Steps and HANDS, have required trainings for providers on cultural competency and family-centered approaches. Specific technical assistance for dealing with visually impaired children and deaf and hard of hearing is specifically contracted in the First Steps program, and available for other programs through the Cabinet Equal Opportunity Office.
CCSHCN is seeing a growing need to provide culturally sensitive training to staff and resources to families who are limited in English proficiency (LEP). CCSHCN has an LEP coordinator who works with office staff to educate on CHFS LEP policies and guidelines. The agency utilizes interpreters and language line services when needed. CCSHCN received technical assistance regarding cultural competency during the past year. The entire CCSHCN staff participated in full day training by Cultureflight, Inc. Public Health and F2F support parents attended this collaborative effort as well. As a result, participants and their agencies are able to better assess the needs of clients from diverse backgrounds and provide more culturally sensitive services. Specific policies are available for review upon request.

C. Organizational Structure

III.C. Organizational Structure

Office of the Governor

Governor Steven L. Beshear took the Oath of Office in December 2007. Governor Beshear has a B.S. and a law degree from the University of Kentucky. He has served the Kentucky in the US Army Reserves, as a State Representative, Attorney General, and Lt. Governor prior to his election. His Lt. Governor, Dr. Daniel Mongiardo is an ENT surgeon from eastern Kentucky who served as a legislator prior to becoming Lt. Governor. He received his B.S. from Transylvania University and his medical degree from the University of Kentucky School of Medicine.

Cabinet for Health and Family Services (CHFS) -- Provision of Health in Kentucky

In Dec. 2003, The Cabinet for Health Services and the Cabinet for Families and Children were consolidated into a single cabinet called The Cabinet for Health and Family Services is the state government agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet includes the following agencies: Department for Public Health, Commission for Children with Special Health Care Needs, Department for Aging and Independent Living, Department for Behavioral Health, Developmental and Intellectual Disabilities, Department for Community Based Services, Department for Family Resource Centers and Volunteer

Services, Department for Income Support, Department for Medicaid Services. The Cabinet for Health and Family Services also includes following program support agencies: Governor's Office of Electronic Health Information, Office of Administrative and Technology Services, Office of Health Policy, Office of Communication and Administrative Review, Office of Human Resource Management, Office of Inspector General, Office of Legal Services, Office of Ombudsman, and Office of Policy and Budget.

Secretary Janie Miller was appointed Secretary of the Cabinet for Health and Family Services in January of 2008. Secretary Miller received her Bachelor's of Social Work from Eastern Kentucky University. Prior to appointment as Secretary for the Cabinet for Health and Family Services, she held the position of Deputy Director of Budget Review for the Legislative Research Commission (LRC), Secretary of Public Protection, Commissioner of the Department of Insurance, and Deputy Commissioner of Health Insurance.

Eric Friedlander was appointed as Deputy Secretary of the Cabinet of Health and Family Services. Prior to his appointment he served as acting Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities, and Executive Director of the Commission for Children with Special Health Care Needs.

Department for Public Health (DPH)

Dr. William Hacker was appointed Commissioner of the Department for Public Health (DPH) in November of 2004. He is Board Certified in Pediatrics and a Certified Physician Executive. He received both undergraduate and medical degrees from the University of Kentucky. Dr. Hacker joined the Department for Public Health as a Physician Consultant in 2001 and served as Branch Manager for the Public Health Preparedness Branch since 2002, where he has headed up the department's disaster preparedness planning efforts. Prior to joining state government, Dr. Hacker's experience included almost 20 years of private pediatric practice in southeast Kentucky, as well as serving as the Chief Medical Officer of Appalachian Regional Healthcare, Inc. He is Board Certified in Pediatrics and a Certified Physician Executive. As the chief health officer of the state, Dr. Hacker serves as a close advisor to Governor Beshear and liason with federal agencies during the natural disasters that occurred in KY in early 2009. The ice storm of 2009 was the worst wintertime natural disaster in the state's history. This was followed by flooding. Then the H1N1 response took everyone's attention. Kentucky's disaster planning and preparation was well tested and many lessons learned; overall performance was commended by federal agencies. Dr. Hacker meets quarterly with the Deans from all the Kentucky-based Colleges of Public Health for sharing information, projects, and ideas.

Dr. Steve Davis was appointed Deputy Commissioner of DPH. He received his undergraduate studies at Morehead State University and his M.D. degree from the University of Kentucky. He practiced pediatrics in eastern KY before coming to Frankfort in 1996, where he has continued to serve tirelessly on behalf of Kentucky's women and children.

The Department for Public Health (DPH) is the government agency in Kentucky responsible for developing and operating all public health programs for the people of the Commonwealth. Kentucky Revised Statute 194.030 created DPH to "develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and treatment of physical disability, illness, and disease." Dr. Hacker says "The Department for Public Health is about 400 employees assisting 4000 Health Professionals to care for over 4 million Kentuckians and we touch their lives in some way every day."

DPH is comprised of seven divisions: The Division of Epidemiology and Health Planning, the Division of Health Protection and Safety, the Division of Lab Services, the Division of Maternal and Child Health, the Division of Prevention and Quality Improvement, the Division of Women's Health, the Division of Administration and Financial Management.

The Division of Administration and Financial Management develops and oversees the Department for Public Health's budget as well as local health department's fiscal planning, allocations and payments, and their administrative and management practices. The division also manages departmental procurement and contracts, information technology and administrative support to local health departments in all 120 counties of the Commonwealth. The division is under the direction of Rosie Miklavcic RN, BSN, MPH.

The Division of Health Protection and Safety protects Kentuckians from unsafe consumer products, lead hazards, radiation and other toxic exposure, unsanitary milk, adulterating and misbranded foods, unsanitary public facilities, and malfunctioning sewage systems. The director of the division is Guy Delius R.S.

The Division of Epidemiology and Health Policy is responsible for communicable disease prevention (immunization, HIV, TB, STD, etc.) and control, disease surveillance and investigation, adult injury prevention and research, maintenance of vital statistics and health data, including hospital discharge data and county health profiles. This division also publishes various health planning documents including the Kentucky Public Health Improvement Plan and Healthy Kentuckians 2010. This Division is also led by a pediatrician, Dr. Kraig Humbaugh. MCH Programs work closely with this division's programs including emergency preparedness, Immunizations, HIV, Communicable disease, and vital statistics. Vital Statistics has implemented an electronic birth certificate for all birthing hospitals. As the result of collaborative efforts, screens for this data also produce the documentation for newborn metabolic screening and universal newborn hearing screening. Kentucky is currently working on a system for electronic death certificates.

The Division of Laboratory Services provides analysis and quality control for health department laboratories and reference services to laboratories. The central lab also conducts metabolic screening for all newborns in the Kentucky. They identify agents from communicable disease outbreaks, as well as from bioterrorism threats.

The Division of Prevention and Quality Improvement oversees the Chronic Disease Prevention and Control, Health Care Access programs, the Quality Improvement program, department training, and the BRFSS. Dr. Regina Washington is the Division Director. She obtained her BA from Berea College, MA in Health Sciences from Eastern Kentucky University, and a DrPH from the University of Kentucky College of Public Health. Programs addressing chronic disease are working towards a more integrated, community-based approach with the Healthy Communities Project. The Tobacco Control program is working with the MCH COordinated School health program on 24/7 tobacco free schools. Obesity prevention is another effort that combines the work of MCH and the chronic disease program staff.

The Division of Women's Health oversees the women's health programs and initiatives in the Department. Their focus is on adolescent, preconcpetion and interconception care, and cancer screening. The Division is described in the Capacity section of this grant. Dr. Connie White is the division director. She is a graduate of Kentucky Wesleyan College with a Bachelor of Science in Chemistry and holds a Master of Science in Toxicology, having worked as a researcher in Teratology at the National Center for Toxicological Research in Little Rock, Arkansas. She later attended medical school at the University of Kentucky. Dr. White completed her OB-GYN residency program at the University of Louisville. She is board certified in OB/GYN by the American Board of Obstetrics and Gynecology with a special emphasis of her work on patient education and preventive medical care.

The Division of Maternal and Child Health (MCH) promotes maternal, child and family health by developing systems of care and by promoting and providing preventive health services to at risk populations. The division has 3 branches including Nutrition Services, Early Childhood Development and Child & Family Health. These are described in the Capacity section. This division, through the MCH Title V grant and other activities, seeks to provide leadership, in

partnership with key stakeholders, to improve the physical, socio-emotional, safety and well-being of the maternal and child health population that includes all of Kentucky's women, infants, children, adolescents and their families. The mission is carried out in collaboration with partner agencies, primarily, local health departments, other state agencies and state universities to increase capacity for clinical and community-based services for the MCH population. At the state level, MCH goals are achieved through policy and program development, special grants, surveillance, consultation, technical assistance, education, training and case management.

Commission for Children with Special Health Care Needs (CCSHCN)

CCSHCN operates under a streamlined organizational structure, pursuant to a 2009 reorganization. The agency employs an Executive Director; a, Medical Director; 2 Division Directors with one Assistant Director; and a full administrative, support, clinical, and audiological staff throughout 12 regional offices.

The Division of Administrative Services provides intake, personnel, training, provider contracting, billing, financial reporting, and health information services. The Division of Clinical & Augmentative Services provides nursing and foster care support services, including clinical operations. This division is organized in an East-West structure for clinical programs, and all therapeutic, transition, parent consultant services, and audiology services through the Early Hearing Detection and Intervention program are organized under separate managers.

CCSHCN's Executive Director and Division Directors are appointed by the Governor, as are members of the Board of Commissioners and the Hemophilia Advisory Committee. The Board of Commissioners provides oversight and approval of the Executive Director's actions. The Board meets quarterly with the Executive Director and senior management to review program status, consult and advise on programmatic concerns, and take voting action as required. The Executive Director, with approval of the Board of Commissioners, appoints members to the Medical Advisory Committee. The Early Hearing Detection and Intervention (EHDI) program also operates under the oversight of the EHDI Advisory Board. The Medical Director oversees the Medical Advisory Committee and recruitment of physicians.

In addition to two contracted parent consultants, the agency incorporates public parent and youth involvement in decisions that impact service delivery. The Parent Advisory Council and Youth Advisory Council are comprised of individuals throughout the state (not just families with children enrolled in CCSHCN services) who hold an interest in children and youths with special health care needs (CYSHCN). Each Council meets quarterly at CCSHCN's Louisville office to discuss pertinent issues, provide training and give input on how CCSHCN can better serve Kentucky families with CSHCN.

An attachment is included in this section.

D. Other MCH Capacity

The Kentucky MCH Division provides leadership to improve the physical, socio-emotional health, safety, and well-being of the maternal and child health population which includes Kentucky's women, infants, children, adolescents, and their families. This is carried out in collaboration with partner agencies, primarily local health departments, other state agencies, and state universities. Staff support clinical and community-based services and infrastructure building through policy development and implementation, research, surveillance activities, technical assistance, consultation, training, education and case management. Staff also provide oversight to the services and activities that focus on the protection and improvement of the health of expectant mothers, infants, preschool, and school age children.

Senior Management

Director, Division of Maternal and Child Health Services (MCH)

Dr. Ruth Ann Shepherd was appointed Director of the Division of MCH on September 1, 2005. She received her B.A. from Asbury College,Wilmore, KY, and her M.D. degree from the University of Louisville School of Medicine. Dr. Shepherd did her residency in Pediatrics at Methodist Hospital Graduate Medical Center in Indianapolis, IN and her Neonatology Fellowship at Medical University of South Carolina in Charleston. Dr. Shepherd is Board Certified in Pediatrics and Neonatal-Perinatal Medicine, and has been a Certified Professional in Healthcare Quality. Her experience includes private practice in Neonatology and General Pediatrics in Louisville (KY), followed by 16 years as Director of Neonatology Services at Pikeville Methodist Hospital, a Regional Level 3A Neonatal Intensive Care Unit with Regional Neonatal Transport Service, and Neonatal Developmental Follow-Up Clinic. She is on the Boards of the Greater Kentucky Chapter March of Dimes and the Kentucky Perinatal Association. Dr. Shepherd has presented on behalf of Kentucky at the American Public Health Association, National Center for Health Statistics, NIH MCH Education Committee, and the Surgeon General's Conference on Preterm Birth. She is served on the National Quality Forum Steering Committee for Perinatal Indicators.

Assistant Director, Division of MCH

Marvin Miller, MSW, is the Assistant Director for the Division. Mr. Miller has worked in public health for over thirty years, and has been assistant director in MCH for over 20 years. Mr. Miller has been instrumental in the development of the WIC program, Well Child Program, and others. A few of his accomplishments include the establishment of EPSDT outreach, a child safety seat program, and the HANDS home visiting program. Some of Mr. Miller's current functions include legislative liaison for the Division, and oversight of the LHD's plan and budget process.

Branch Manager, Child and Family Health Improvement (CFHI) Branch

Shelley Adams, MSN, RN, became the Branch Manager of CFHI on March 1, 2009. Ms. Adams came to Public Health from the Department for Medicaid Services after 4 years working primarily with community mental health and waiver programs as a Nurse Consultant Inspector, then as a branch manager in Community Alternatives. Ms. Adams has a Bachelor of Science in Nursing from Northeast Louisiana University and a Master of Science in Nursing from the University of Phoenix. Ms. Adams is the Authorizing Official of the MCH Block Grant and oversees the Prenatal, Pediatric, and Oral Health Programs.

Branch Manager, Nutrition Services Branch

Frances M. Hawkins manages the Nutrition Services Branch. Ms. Hawkins coordinates the branch, which administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Adult and Child Health (ACH) Nutrition Program, the Fruit and Veggies More Matters Program, the Breastfeeding Peer Counselor Program, the WIC Farmers' Market Nutrition Program (FMNP). Ms. Hawkins received her training at Indiana University of Pennsylvania and her Master's degree at the University of Kentucky. She has managed the Nutrition Services Branch since 1996 and is a registered, licensed dietitian.

Branch Manager, Early Childhood Development Branch (ECD)

Sandy Fawbush, RN, BSN is the ECD Branch Manager. She oversees many of the birth to three public health programs, including HANDS, First Steps and newborn screening. Ms Fawbush has been the database manager and coordinator of medical records abstraction for the Kentucky Birth Surveillance Registry for over 9 years, and led the development of KY's expanded newborn screening case mangement program. She has 25 years of nursing experience and worked on system wide quality assurance and control issues in Kentucky hospitals and chains. Ms. Fawbush has trained with Columbia HCA on coding compliance, and has experience in hospital

data systems and their reporting capabilities.

Director, Division of Women's Health (WH)

Connie Gayle White M.D. was appointed the Director of the Division of WH in March, 2009, joining the division after practicing obstetrician/gynecologist for over 20 years in Frankfort, Kentucky. She is a graduate of Kentucky Wesleyan College with a Bachelor of Science in Chemistry. She received a Master of Science in Toxicology and worked as a researcher in Teratology at the National Center for Toxicological Research in Little Rock, Arkansas. She later attended medical school at the University of Kentucky. She completed her OB-GYN residency program at the University of Louisville. She is board certified in OB/GYN with a special emphasis of her work on patient education and preventive medical care. Dr. White's professional activities include the Board of Trustees Frankfort Regional Medical Center (chair 2007-2008), American Congress of OB/GYN (ACOG), and ACOG Kentucky Section (Chair 2007-2010, Vice President 2006, Secretary/Treasurer 2004-2006). She has been active on the Planned Parenthood of the Bluegrass Board of Directors, Frankfort United Way, Frankfort Arts Foundation and Medicaid Therapeutics Advisory Committee. Dr. White currently serves on the KY Cancer Consortium Advisory Board, the KY Colon Cancer Advisory Board, and is a member of the KY Perinatal Association. She is also the current President of the Breast Cancer Education and Research Trust Fund.

Assistant Director, Division of WH

Natalie Lonkard, ADN, BSN, MHCA, became the Assistant Director of the Division of WH in September, 2009. She has over 23 years experience in nursing with a Bachelor of Science in Nursing from McKendree College in Louisville, Kentucky and received her Master of Science in Public Health Care Administration from Bellevue University in Bellevue, Nebraska in 2005. Lt. Colonel Lonkard has served in the Kentucky National Guard Medical Command Unit for over 21 years. She worked as an OB/GYN Staff RN, Manager and House Supervisor at Frankfort Regional Medical Center for 27 years. Lt. Colonel Lonkard came to DPH with a strong women's health background, certified in Inpatient Obstetrics since 2001.

Title V Administrator

Jo Ann Blackburn, CSW, MSSW, ACSW assumed her role as the Health Services Section Supervisor in November of 2009. She has twenty years of experience as a medical social worker in a variety of healthcare settings and is now the administrator of the Title V Block Grant for Kentucky. Ms. Blackburn supervises, coordinates, and administers the activities of the staff of the Pediatric Section of the CFHI Branch. These programs include the Child Fatality Review and Injury Prevention Program, Childhood Lead Poisoning Prevention Program, Coordinated School Health Program, EPSDT and K-CHIP Outreach Program, School Health Program, and the Well-Child Program. She holds a bachelors degree in Social Work from Eastern Kentucky University and a Master of Science in Social Work from the University of Louisville.

State Dental Director

Julie McKee, DMD was named the State Dental Director in September 2007. Dr. McKee has a BS in Biology from the University of Kentucky and her DMD from the University of Louisville. Prior to her appointment, Dr. McKee was the Director of the WEDCO District Health Department for more than 12 years. Dr. McKee has been instrumental in expanding the Kentucky Oral Health Program to serve citizens of Kentucky and has successfully secured major HRSA and Appalachian Regional Commission grants to work toward increasing dental services for children in the state.

MCH Epidemiologist

Tracey D. Jewell, MPH is the lead maternal and child epidemiologist for the MCH Division. Ms. Jewell earned her Master of Public Health degree at the University of Alabama Birmingham, School of Public Health in 1998. She joined the staff at the DPH in February of 1999 and came to the MCH Division in January of 2001 to assume her present position. Effective September 1, 2005, Ms. Jewell was promoted to Lead Epidemiologist for the Division of Maternal and Child Health. Ms. Jewell is involved in all MCH epidemiology efforts.

Director, Office of Health Equity (OHE)

Torrie T. Harris is an Assistant Professor in the Health Systems Management DPH. Dr. Harris is also Director at the OHE for the Kentucky DPH. She received her Dr.P.H. from the University of Kentucky, College of Public Health in Health Behavior. Prior to coming to UK, she received a B.S. in Chemistry from Xavier University of Louisiana and her Masters of Public Health at Tulane University School of Public Health with a concentration in MCH. Dr. Harris worked extensively on MCH programs studying infant mortality and morbidity, child passenger safety, minority health, and public mental health.

Commission for Children with Special Health Care Needs -- Senior Management Staff

In 2008, the Commonwealth of Kentucky experienced widespread retirement as a result of a designated retirement window preceding legislatively-mandated retirement benefits. The Commission for Children with Special Health Care Needs (CCSHCN) was no exception.

Executive Director -- Rebecca Cecil, R. Ph., has served as CCSHCN's Executive Director since 2008. Ms. Cecil brings more than 20 years of experience to the position, including serving as CCSHCN's Director of Health and Development for 3 years, and Interim Executive Director immediately prior to her appointment. Before her tenure at CCSHCN, Ms. Cecil served as Deputy Undersecretary for Health, Acting Commissioner of Mental Health and Retardation Services, and Director of Licensing and Regulation with the Office of Inspector General. Ms. Cecil is a 1979 distinguished graduate of the University of Kentucky's College of Pharmacy.

Medical Director -- Richard McChane, MD, has served as CCSHCN's Medical Director since March, 2007. Dr. McChane is also the Medical Director of the Home of the Innocents, serves as a developmental pediatrician at the University of Louisville Weisskopf Child Evaluation Center, and is a faculty member with the University of Louisville School of Medicine -- Department of Pediatrics.

Director of the Division of Administrative Services- Shelley Meredith has served as director of CCSHCN's Division of Administrative Services since October 2008. Ms. Meredith has over 22 years experience with state government, 19 of which have been with the Cabinet for Health and Family Services in the health care arena. Ms. Meredith played a key role in the establishment and development of the CCSHCN's health information system and electronic patient record and is now responsible for managing all the operational functions of CCSHCN including budgets, contracts, purchasing, accounts payable and receivable, health information and technology, personnel, and grant reporting. Ms. Meredith is a Certified Public Accountant and 1985 graduate of the University of Kentucky with a BS in Accounting and a minor in Economics.

Director of Clinical & Augmentative Services -- Anne Swinford has served as a CCSHCN director since 2005. Ms. Swinford's previous experience includes the provision of direct care services to the special needs population, and serving as the Acting Part C Coordinator and supervisor of Kentucky's early intervention program (First Steps). Ms. Swinford is a graduate of Brescia University and Purdue University, where she earned a BA in Speech and Hearing and a MS in Speech Pathology.

Title V MCH Block Grant Coordinator -- Mike Weinrauch serves as CCSHCN's Title V coordinator. Other areas of focus include technical assistance with foster care support programs,

social work with the bleeding disorder population, guidance to staff on brokering community resources, and general policy analysis/program evaluation. Prior to employment with CCSHCN, Mr. Weinrauch served in KY's child welfare & adult protective services agency as a field worker/supervisor and administrator at regional and state levels. Mr. Weinrauch is a graduate of the University of Vermont (BA), the University of Kentucky (MSW), and the University of Louisville.

E. State Agency Coordination

Collaboration -- Local Health Departments (LHD)
LHDs provide services in cooperation with the Title V program in all 120 counties. These include WIC, EPSDT and Well-Child Preventative exams, Immunizations, Family Planning, Breast and Cervical Cancer Screening, HANDS Home Visiting, and many other programs. Many health departments provide EPSDT and preventative pediatric services in the school settings, improving access to these servcies for children. Currently 19 LHD's provide an in-house prenatal clinic; others assure prenatal care thru a local obstetrician medical home. Women diagnosed as pregnant through the Family Planning program, or presenting to the health department pregnant for any reason, are assisted in applying for Presumptive Eligibility for Medicaid if appropriate for their income levels. This provides coverage for 90 days while they go thru an official eligibility determination. Prenatal servcies for the uninsured are funded through an allocation from the Title V MCH BLock grant. All LHD programs are trained to screen and refer for smoking cessation. The LHDs operate under the Kentucky Public Health Practice Reference (PHPR) standards of care for delivery of all clinical services. Data on encounter services provided is captured through a single data system, allowing for thorough review and analysis of all services rendered.
DPH has the capacity to connect with LHDs and hospitals across the state through a tele-health network. The network is used for training, state-wide educational meetings for public health nurses, and also is a method for communication during distasters or epidemics.

Collaboration -- Department for Medicaid Services (DMS)
KenPac: The Kentucky Patient Access and Care (KenPAC) Program is a primary care case management program that increases access to primary and preventive health services and coordinates other Medicaid covered health care and related services for Medicaid members eligible to participate in the program. A pediatrician, internist, family doctor, general practitioner, OB/GYN, rural health clinic, primary care center or nurse practitioner acts as the primary care provider (PCP) for Medicaid members enrolled in KenPAC. Kentuckians who receive financial assistance through the Kentucky Transitional Assistance Program (K-TAP), [formerly Aid to Families with Dependent Children (AFDC)] and adults aged 19 and older who receive Supplemental Security Income (SSI), are enrolled in the KenPAC program. The KenPAC program has regional nurses that are located around the Commonwealth in areas with high Medicaid population densities. The KenPac care coordinators serve as a liaison between Medicaid and the KenPAC providers, and local health departments.

KCHIP: Eligibility is determined by the Dept for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid. KCHIP members enrolled are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

DPH has a long history of working cooperatively with the Department for Medicaid Services. This relationship continues through several Interagency Agreements (Memorandum of Agreement or MOA) that are renewed annually. The programs included in these agreements include:
-The preventive health services delivered to Medicaid recipients by local health departments and reimbursed by the DMS.
- The early intervention services for Medicaid-eligible infants and toddlers who are determined eligible for First Steps, Kentucky's Early Intervention System, authorized by the Individuals with

Disabilities Education Act and reimbursed by DMS.
- The Health Access Nurturing and Development Services Program (HANDS) for home visiting services to Medicaid-eligible pregnant women, parents and children and are reimbursed by the DMS.
- The Medicaid Services Presumptive Eligibility Program for Pregnant Women allows pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.
- The Breast and Cervical Cancer Treatment program provides cancer care to women diagnosed in the DPH program that have no payor source.

In general, children and pregnant women in Kentucky are well supported through the KCHIP and Medicaid insurance systems. The service gap identified is for the adult males and non-pregnant females and low income families who do not qualify for public support. Many local health departments provide safety net services for these populations.

Collaboration -- Department for Behavioral Health, Developmental and Intellectual Disabilities and Addiction Services (BHDIDAS) is a collaborative partner on a number of maternal and child health programs:

- The KIDS NOW Substance Abuse in Pregnancy program targets women at risk or abusing alcohol, tobacco, and other drugs during pregnancy. Health departments screen pregnant women for alcohol, tobacco, and other drugs and women who fall into lower level risk groups can be referred for prevention services, while those in the high risk category can be referred for a fuller substance abuse assessment and case management to the Regional Mental Health centers. As a result of this collaboration, thousands of pregnant women struggling with substance abuse issues in Kentucky are being reached.

- The Early Childhood Mental Health (ECMH) Program, funded by KIDS NOW and co-administered by MCH and DBH, provides direct services to children identified through childcare as having behavioral or possible mental health issues. Through this program there is a full time early childhood mental health consultant located in each regional mental health center to provide or refer these services. They also provide consultation to the childcare center and train childcare staff to problem solve classroom behavior problems and build resiliency in children. Another component of this program is to build capacity of mental health professionals working with children birth to five years of age by providing free trainings. This program has been presented as a "Model that Works" at the Association of Maternal and Child Health Programs (AMCHP) national meeting in 2006. The Specialists work collaborative with the HANDS program and the Child Care Health Consultation program to identify families in need of services; they are also trained to deal with Perinatal Depression.

- MCH staff serves on the Suicide Prevention Advisory Group. DBHDID staff also serves as a member of the State Child Fatality Review Team.

- Substance Exposed Infants: The Substance Abuse Prevention team in MHMR, as part of the KIDS NOW Early Childhood Development Initiative, has been working with many of the MCH programs including the Prenatal program, Family Planning, Well Child and the Kentucky Birth Surveillance Registry. This collaboration is a statewide effort aimed at increasing the health of all babies by decreasing the use of alcohol, tobacco and other drugs during pregnancy. The program components will include outreach efforts aimed at better identifying pregnant and postpartum women in need of prevention or treatment, and collaborative efforts between substance abuse prevention and treatment services to provide a continuum of care.

- Collaborations at the Commissioner's level include the State Interagency Coordinating Council (SIAC) for Children with Emotional Disabilities. which is currently chaired by the Commissioner of Public Health. This is the oversight body for the KY SEED project, continue with the KY SEED Grant -- Systems to Enhance Early Development. This is a $9 Million SAMSHA grant to develop

and implement integrated systems of care for familes of children birth to five who have social, emotional, and behavioral needs. Several MCH program staff, including the HANDS program, are participating in this collaborative effort. The KY Partnership for Families and Children is the family voice for this initiative.

Collaboration -- Kentucky Department of Education (KDE)
The KIDS NOW Initiative is housed in the Department of Education, Division of Early Childhood, but works across department lines with Public Health, Education, Commission for Children with Special Health Care Needs, Child Care, and Mental Health. The goal of the initiative and all partners is that "all children in Kentucky are healthy and safe, possess the foundation that will enable school and personal success, and live in strong families that are supported and strengthened within their communities." There is a strong evaluation component of the entire initiative and programs regularly report their progress to the Early Childhood Development Authority board, which makes funding recommendations and provides accountability.

Kentucky receives a Coordinated School Health grant from the Centers for Disease Prevention and Control - Division of Adolescent School Health (CDC-DASH). This allows a continuation of the infrastructure building and program development to promote the health of our youth so that our children become healthy, productive citizens. The Kentucky Dept of Education (KDE) and the Kentucky Dept for Public Health (KDPH) partner together to administer and evaluate a coordinated school health program at the state level. Through this state infrastructure, schools and school districts, with assistance from local health departments and other partners, strengthen local CSH Programs.

CSH consists of an eight-component national model include health education, physical education, health services, nutrition services, counseling/psychological services/social services, health school environment, health promotion for staff and family/community involvement. This model is an organized set of policies, procedures, and activities designed to promote and sustain the health of students and staff. Many other programs within the Division are linked with this project, specifically through a CSH Interagency committee, which includes representatives from Tobacco, Substance Abuse Prevention, Asthma, HIV/AIDS, Well-Child, Abstinence Education, Family Planning, Diabetes, Nutrition, Obesity, Cardiovascular Health and Physical Activity. The Foundation for a Healthy Kentucky (http://www.healthyky.org/), has supported coordinated school-based projects through funding of school grants to expand, replicate or enhance Coordinated School Health Programs in Kentucky communities. This group has developed a school-based resource guide book on physical activity, nutrition, tobacco and asthma (PANTA). The handbook was developed by the Kentucky Dept for Public Health and the Kentucky Dept of Education to provide assistance to schools in designing and planning policies and programs, encouraging environmental change, and promoting overall health of students, staff and the school community. This resource helps schools make the changes required by SB 172, our school nutrition bill. Resources are provided that encourage needs assessment [CDC's School Health Index], evidenced-based curriculum, best practices, model policies and answers to frequently asked questions. This guide is arranged in such a manner that it can be used as a whole document or by subject -- physical activity, nutrition, tobacco and asthma (PANTA). This guide is currently in the process of being updated, and adding sections on drug and alcohol use, injury and violence (including suicide), sexual risk behaviors, and dental health.

School health nursing is another area of collaboration. By law, DPH funds half of a position for a school health nurse consultant at the Dept of Education, and Education funds the other half. This nurse consultant works in partnership with the MCH School nurse consultating, providing leadership, technical assistance, protocols, training, and alignment with the KY Board of Nursing for nurses in the school setting. About half of the school health nurses in KY are now health department nurses; others are employees of the local school districts.

Collaboration - Univeristy of Kentucky
UK houses the KY Injury Prevention Research Center, which works with the DPH Child Fatality

Review and Injury Prevention program to facilitate, develop policy, gather and analyze data to identify trends, patterns and risks, provide technical assistance and training, and to review, make proposals and implement strategies to improve the child fatality review and injury prevention system, with an emphasis on coordinating partnership prevention efforts. The Injury Prevention center also works with the DPH Epidemology Division on statewide injury surveillance and cooperates with CDC on the Violent Death Reporting System.

The DPH also has an active collaboration with the state-wide network of county extension agents through the UK Cooperative Extension Agency. Community topics include nutrition, physical activity, smoking cessation and general health promotion.

Collaboration -- Commission for Children with Special Health Care Needs

CCSHCN coordinates an MOA with the Department for Medicaid Services that enables the agency to provide services for applicable Medicaid eligible children enrolled for Title V/CYSHCN services. This agreement assures that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89.

CCSHCN also operates under an MOU with the Department for Community Based Services (DCBS) and is providing nursing consultative services in 8 of the 9 DCBS regions for children in the foster care system. This program was initiated in February 2005 to provide services for children who are medically fragile. It was expanded statewide in July 2006 to include the entire foster care population. The Nurse Consultants who work with this program provide consultation to the DCBS social workers and foster care families on medical issues, interpret medical records and reports, assure updated medical passports and enhance care coordination of all services. In November 2007, it was further expanded in a collaborative effort with the University of Kentucky to open (via a separate Memorandum of Agreement) the Medical Home for Coordinated Pediatrics in the Lexington office, which provides primary care services to foster children children in the central region of the state.

The Early Hearing Detection and Intervention (EHDI) program maintains many relationships in the administration of Kentucky's legislatively mandated newborn hearing screening program. In addition to the partnerships with the state's birthing hospitals, the program collaborates with the Commission on the Deaf and Hard of Hearing and the Kentucky chapter of Hands and Voices. Since 2006, a partnership with the Office of Information Technology (OIT) has allowed the program to receive newborn hearing screening results for every child born in Kentucky electronically through the KY-CHILD database. Ongoing efforts at this time include work with OIT to expand online data transmission to allow community audiologists and early interventionists to electronically transmit diagnostic assessment results and early intervention service notes to the EHDI program. New efforts are focused on working with Part C leaders to further implement Early Intervention services that more effectively meet the specific needs of newborns diagnosed with permanent hearing loss. In March 2009, Governor Beshear signed HB 5 which requires audiology diagnostic sites who wish to be included as approved centers for pediatric audiological testing to agree to meet specific requirements, including best practice standards and reporting to the EHDI program.

An agency partnership with Home of the Innocents allows Louisville therapeutic staff (PT, OT, SLP) to reside and provide services at the Home of the Innocents facility. This arrangement allows CCSHCN patients and staff to utilize the advantages of a new facility, with state-of-the-art equipment, that is closer to the downtown area & medical complexes.

Memoranda of Agreements are maintained with the University of Kentucky and the University of Louisville to provide Hemophilia Treatment Centers covering the entire state's bleeding disorder population

CCSHCN also provides assessments for the state's Disability Determinations Services division

on behalf of the Social Security Administration for residents of Kentucky.

Currently, CCSHCN is working towards Memoranda of Agreement with First Steps to provide audiological services and to improve and streamline interpretation services.

CCSHCN collaborates with the Kentucky Council on Developmental Disabilities (KCDD). The mission of the Kentucky Council on Developmental Disabilities is to create change through visionary leadership and advocacy so that people have choices and control over their own lives. Note: KCDD does not provide direct care services. The Kentucky Council on Developmental Disabilities was authorized by Executive Order of the Governor, in accordance with Public Law 106-402, the Developmental Disabilities Assistance and Bill of Rights Act. The KCDD is comprised of 26 members, 16 of whom are appointed by the governor. The makeup of the KCDD is unique in that 60 percent of its members are individuals with developmental disabilities or are parents or guardians of individuals with disabilities. The remaining members are representatives of each major state agency that serves people with developmental disabilities in Kentucky. KCDD membership also includes representatives from the state's University Center for Excellence in Developmental Disabilities and the state's Protection and Advocacy system.

CCSHCN maintains numerous additional relationships with other state agencies. Programs with which our agency collaborates include: local schools, Office of Vocational Rehabilitation, First Steps (Kentucky's Early Intervention Program), Special Needs Adoption Program, University of Kentucky, University of Louisville, Eastern & Western Kentucky Universities, Owensboro Community Technical College System, local health departments, Family Resource Youth Service Centers, Regional Interagency Transition Teams (RITT), State Early Childhood Transition Committee, KIDS NOW, State Interagency Council on Services to Youths with Severe Emotional Disabilities, and the state Child Fatality Review Program. Agency association with these entities allows us to further develop goals for the agency, provide community training, streamline services for children with special health care needs in their community and schools, as well as prepare children for the transition into adult health care

F. Health Systems Capacity Indicators

Introduction

The Department for Public Health, Division of Maternal and Child Health has made significant improvements in its capacity for data analysis and utilization. The SSDI grant has enabled MCH to bring in high quality trainings for epi staff that would have otherwise been impossible, as well as techical assistance from buisness school professors, biostaticians, and other experts in advanced analysis. In addition, we have been able to achieve linkages of databases that provide a richness and depth of information previously unavailable to the program. Plans for further linkages and analysis continue to grow, and these will allow for more specific, data driven strategies and programs that will be required in tight economic times.

The state MCH programs work closely with Medicaid and other agencies to develop strategies to enhance Health Systems Capacity as measured on these indicators. Kentucky Medicaid has been very supportive of providing care for MCH populations. The Medical Director for Medicaid, Dr. Tom Badgett, is a pediatrician.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	56.2	47.8	45.8	78.8	78.8

Numerator	1541	1315	1276	2244	2244
Denominator	274199	274947	278330	284601	284601
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 KY inpatient hospital discharge data will not be available until late summer of 2010; therefore, the 2009 numbers actually reflect 2008 data.

Data includes a primary, secondary or tertiary diagnosis code of 493.0-493.9.

Notes - 2008
Data includes a primary, secondary or tertiary diagnosis code of 493.0-493.9.

Notes - 2007
Data includes a primary, secondary or tertiary diagnosis code of 493.0-493.9.

Narrative:
This indicators shows a significant increase, but we have concerns it may be an issue of how the data is pulled. The increase in hospitalizations could also be a result of better reporting and/or public awareness concerning asthma resulting in better diagnosis. Either way, this is an important issue in KY, and particularly for children. Kids Count estimates that 40% of KY's children are exposed to second hand smoke, and that alone could trigger hospitalization. While we have made progress in addressing environmental tobacco exposure, with 27 Ky communities now having smoke-free ordinances, there is no state-wide policy in place.

Though not in the responsiblities of the MCH Director, DPH has an active program for Asthma control. The Kentucky Respiratory Disease Program completed the Kentucky Asthma Surveillance Report, 2009 and the 2009 Kentucky State Plan for Addressing Asthma. Stakeholders included pediatric pulmonologists from both main medical centers, public health nurses, school nurses, certified asthma educators, health educators, parents, and others. Both documents are being distributed to key partners and have been made available on the programs web-site. The Kentucky Asthma Surveillance Report provides data reflecting the burden of asthma in Kentucky. Data from this report provided important information used to direct the efforts of the Kentucky Asthma Partnership during the strategic planning process to create the state plan. The 2009 Kentucky State Plan has several strategies that are relevant to MCH populations, which include:

DPH is partnering with the Kentucky Department of Education, the Kentucky School Boards Association, and the Kentucky Association of School Administrators to develop a statewide asthma management plan for Kentucky schools. The plan would include collecting data and providing information to key partners and stakeholders; educating school administrators, faculty, staff, and students on appropriate asthma management and emergency response; and communicating among schools, students with asthma, their parents and their physicians.

DPH also works with the American Lung Association of Kentucky to promote their Asthma Educator Institute to local health department employees who are interested in becoming Certified Asthma Educators.

DPH has initiated an Asthma pilot program in Montgomery County that includes education,

collaboration with local physicians, partnering with school nurses on asthma management and building of a community coalition. The Montgomery County Asthma Pilot Program also works with promotoras program to educate the Spanish speaking community.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	77.0	78.8	78.8	72.0	72.2
Numerator	16624	17626	17626	51098	52452
Denominator	21580	22354	22354	70991	72637
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Preventive codes for periodic screen based on the HEDIS specifications included the following codes: 99381,99382,99391,99392,99432,V202,V703,V705,V706,V708, and V709

Notes - 2008
Numerator and denominator calculations have changed for this indicator. For numerator information, the HEDIS technical specifications for well child visits as accepted for HEDIS measures was used to determine procedure and diagnosis codes used for periodic screen. The HEDIS measures were used since they are a recognized national standard and would provide consistency in reporting over time.

Preventive codes for periodic screen based on the HEDIS specifications included the following codes: 99381,99382,99391,99392,99432,V202,V703,V705,V706,V708, and V709

For denominator information, the age calculation changed for determining eligibility. Since age is not static, a child could have been born in the previous year but still be eligible for services and under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Narrative:
The Department for Medicaid services administers statewide EPSDT Outreach through a contract established with the Kentucky Department for Public Health (KDPH). EPSDT outreach further expanded verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs. The Department for Public Health enhances EPSDT Outreach providing technical assistance and helping health departments set specific goals and objectives including KCHIP Outreach activities, monitoring statewide and county outreach activity and expenditures goals and objectives quarterly and as needed, providing local health departments with training and technical assistance as well feedback about program performance, and collaborating with the Department for Medicaid services and health departments in 120 counties to increase public and provider awareness of KCHIP and increase enrollment. The Department for Public Health enhanced statewide local health department outreach EPSDT

verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs. Additionally, the DPH EPSDT Outreach program participated in statewide videoconferences provided to health departments to promote outreach budget and planning, EPSDT Outreach goals and objectives, and provide education about appropriate outreach coding and reporting.

Through CY 10, local health departments in 120 counties helped enroll more children in Medicaid and KCHIP while working with community agencies to improve partnerships with schools and providers, conducting EPSDT outreach verbal notification activities to inform families of the need for children's preventive health exams, and providing families with materials and assistance to complete KCHIP applications. The Department for Public Health has proceeded with EPSDT Outreach program improvements in state fiscal year 2009 and reinforced EPSDT Outreach goals and activities for state fiscal years 10 and 11, DPH provided EPSDT Outreach training presentations through two (2) statewide videoconferences attended by health department administrators and EPSDT clinical and support staff members. Work has begun in partnership with the DPH Oral Health and Lead Poisoning Prevention programs to leverage outreach efforts and promote preventive screening services. Additionally, the Department for Public Health will improve education about EPSDT services using the statewide KCHIP outreach hotline to provide information about enhanced statewide local health department outreach EPSDT verbal notification activities. Further training will be developed and made available via TRAIN by videoconference and webcast to local health department administrative, clinical and support services staff regarding the EPSDT Outreach verbal notification process, budget and planning, reporting and performance improvement.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.0	84.1	79.9	61.4	50.2
Numerator	372	371	528	308	267
Denominator	459	441	661	502	532
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Numerator and denominator calculations have changed for this indicator. For numerator information, the HEDIS technical specifications for well child visits as accepted for HEDIS measures was used to determine procedure and diagnosis codes used for periodic screen. The HEDIS measures were used since they are a recognized national standard and would provide consistency in reporting over time.

Preventive codes for periodic screen based on the HEDIS specifications included the following codes: 99381,99382,99391,99392,99432,V202,V703,V705,V706,V708, and V709

For denominator information, the age calculation changed for determining eligibility. Since age is not static, a child could have been born in the previous year but still be eligible for services and

under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Notes - 2008
Numerator and denominator calculations have changed for this indicator. For numerator information, the HEDIS technical specifications for well child visits as accepted for HEDIS measures was used to determine procedure and diagnosis codes used for periodic screen. The HEDIS measures were used since they are a recognized national standard and would provide consistency in reporting over time.

Preventive codes for periodic screen based on the HEDIS specifications included the following codes: 99381,99382,99391,99392,99432,V202,V703,V705,V706,V708, and V709

For denominator information, the age calculation changed for determining eligibility. Since age is not static, a child could have been born in the previous year but still be eligible for services and under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Narrative:
After a period without active grass roots KCHIP Outreach from CYs 2004-2008, effective November 1, 2008, Governor Beshear initiated a statewide plan to increase the number of children enrolled in KCHIP by more than 35,000 children. The following Department for Medicaid Services administrative changes were implemented and decreased barriers that have kept families from enrolling their children in the Kentucky Children's Health Insurance Program (KCHIP): eliminating the face to face interview, simplifying the KCHIP application, distributing KCHIP Mail In applications, extending the grace period for replying to requests for more information to complete applications, training statewide community providers and agencies to assist families with enrollment processes, hiring more personnel to process applications and increase outreach. In state fiscal year 09, the Department for Medicaid Services hired a full-time Outreach Coordinator and partnered with the KDPH, local health departments, statewide community providers and agencies to increase awareness of KCHIP and conduct outreach to the children estimated to be uninsured in Kentucky and to enroll additional children in KCHIP by June 30, 2010. The Department for Public Health and the Department for Medicaid Services contracted to conduct EPSDT Outreach through activities through statewide local health department Health Access Nurturing Development Services as well as EPSDT Outreach programs.

The Department for Public Health enhanced EPSDT Outreach in state fiscal year 2009 by increasing guidance on specific goals and objectives including KCHIP Outreach activities, monitoring statewide and county outreach activity and expenditures goals and objectives quarterly and as needed, providing local health departments with training and technical assistance as well feedback about program performance, and collaborating with the Department for Medicaid services and health departments in 120 counties to increase public and provider awareness of KCHIP and increase enrollment. To increase provider awareness of KCHIP and facilitate enrollment, DPH and DMS partnered to present statewide videoconferences to health departments and statewide community providers, schools and agencies. The videoconference was made available to partners on line through TRAIN. Additionally, the Department for Public Health maintained and monitored contracts with two health departments to administer the statewide KCHIP outreach hotline, providing information about KCHIP enrollment and enhanced statewide local health department outreach EPSDT verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs. The decrease reflected in 2009 is due to providers of EPDST services have up to one year to file a medicaid claim thus services provided may not be reflected in the number above. Due to the current economic times many families in rural areas are have transportation problems.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	70.5	75.4	73.4	75.6	74.1
Numerator	37800	42150	42704	42984	40881
Denominator	53647	55893	58164	56892	55140
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
2008 data is preliminary.

Notes - 2007
2007 data is preliminary.

Narrative:
Following Kentucky's switch to the new birth certificate in 2004, this indicator was calculated differently than in the past and therefore the numbers are not comparable. Like other states who switched, we struggled with how to best calculate this indicator based on the new data source. We currently use the method established by the NCHS for calculating entry into prenatal care. Due to this new method change, we have seen a decline in the percent of women with adequate and adequate plus prenatal care. Detailed multi-variate logistic regression analysis has been conducted to assess if the decline is real. Results from the analysis comparing births pior to and after the new birth certificate indicate the decline is due to the new method of calculation and not a reflection of decline in the receipt of services, since significant demographic variables remained the same for both groups of women that received adequate and adequate plus prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	89.2	97.8	91.5	94.4	95.8
Numerator	361554	470710	436253	461330	494162
Denominator	405239	481324	477020	488685	515858
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Medicaid claims can be paid for up to one full year from the date of service so the data is not complete and still considered to be preliminary.

Narrative:
This number reflects an increase in the number of children who have received a services and is most likely due to increasing services provided by local health department nurses in the school setting. Local health departments collaborate with local school boards for provisions of child and adolescent preventive health services in a school on site clinic setting, promoting improved access to health information and preventive health services for school age children. Health departments around the state now have around 350 nurses providing school health services locally.

In order to meet the demands for the increased number of services the Well Child Certification training process has changed. The web-based curriculum on Bright Future and EPSDT for health care providers is presented as 23 web casts. The web cast provides a pre and post-test with printable handouts attached with each web cast. After successful completion of the 23 web casts and passing the post-test, the health department nurse participates in a practicum where he/she completes in a teaching setting physical exams for the following age groups, infant, toddler, preschool age child, school age child, and adolescent. Upon completion of these two requirements the nurse then receives a certification to provide well child/EPSDT services. Updates are provided annually. By re-designing the training to include a web-based component, DPh was able to train 147 nurses in 2009, an increase of over 50%.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	35.1	49.4	50.6	43.6	52.1
Numerator	31127	35206	38417	55116	56874
Denominator	88766	71302	75954	126302	109185
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
Numerator and denominator calculations have changed for this indicator. For numerator information, Passport, the managed care portion of Medicaid that includes 16 counties in KY was included in 2008 when it had not been included previously.

For denominator information, the age calculation changed for determining eligibility. Since age is

not static, a child could have been born in the previous year but still be eligible for services and under one year of age in the following year; therefore, calculations were adjusted to reflect this and enrollment numbers have changed.

Narrative:
In 2006, the Kentucky General Assembly increased Medicaid reimbursement rates for dental services to Kentucky children by approximately 30 per cent. The Kentucky Dental Association continued to be proactive in their promotion of Kentucky dentists serving children eligible for Medicaid and KCHIP. This association was also the lead champion of HB 186, which requires a dental examination or assessment for all incoming five and six year old students into the public school system.

Strong partnerships have been developed between the Kentucky Oral Health Program, local health departments and dentists, to promote dental care for Medicaid and KCHIP eligible children, particularly the very young patient, ages 1-5 years. Kids Smiles Fluoride Varnish trainings were provided at 33 regional training sites to approximately 1600 health department nurses and other providers since 2003. For CY09, 41,071 Pre-packaged fluoride varnish kits were provided to local health departments and Commission clinics. Fluoride varnish is now part of the Medicaid Preventive Health package delivered by the state's health departments. Local coalitions who target local issues related to pediactric oral health are under development.

Kentucky's sealant program funded sealant activities in fifteen local health departments. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to purchase portable dental exam equipment. These partners worked together to provide screenings and sealants on Kentucky 2nd, 3rd and 6th graders throughout the Commonwealth. Targeted schools have an increased number of Medicaid eligible children.

The HANDS Home Visitation Program stressed the importance of oral health to overall health for Kentucky's children and their families during HANDS services to over 10,967 Kentucky families and completion of 137,230 (over 11,000 a month) home visits. Through a separately defined part of the home visit, the Case Management Nurse Professional is providing fluoride varnish application to all eligible children in the HANDS client's home.

Eighty-five Second Year students at the Pikeville College of Osteopathic Medicine completed 4 days of Oral Health training.

Kentucky's Oral Health Program is a recipient of a HRSA grant that will train general dentists in effective pediatric dental management with emphasis on the young Medicaid population. The development of the curriculum and its delivery will greatly expand the capacity of the dental delivery system as more generalists become competent in treating this population.

Kentucky is a recipient of a HRSA TOHSS grant, which among their objectives is to develop a referral system for sealant patients that are identified as needing restorative care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	9.8	7.3	7.1	6.9
Numerator	2176	2255	1797	1795	1794
Denominator	22902	22902	24709	25335	26030

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source for numerator is the CCSHCN database. Data source for denominator is the Social Security Administration.

Narrative:
Within the past year, CCSHCN has gone from a paper system of notification to an electronic data exchange system with the Social Security Administration and the state Department for Disability Determination so that the agency has the ability to identify patients with SSI benefits as they are approved.

Although the annual indicator has declined slightly relative to the total number of applicants approved across the entire state, the CCSHCN's percentage of enrolled SSI recipients compared to overall CCSHCN population served has increased slightly. CCSHCN often finds itself acting in the referral role for those who have not been approved for benefits and is able to assist with documentation necessary to reapply for SSI. The agency's website also contains information and resources for SSI, or clients may contact agency staff directly for assistance.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	10.5	7.3	8.8

Narrative:
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. The comparison data is obtained from payer source information on KY Birth Certificates. Data Linkage between Vital Statistics and Medicaid for this Health System Capacity indicator is planned but has not been achieved at the time of this submission. However, we are aware that the birth certificate payor information may not be an accurate reflection of the whole Medicaid population.

The WIC supplemental nutrition program for pregnant women provides improved nutrition and supplements to enhance the nutrition of low income women through their pregnancies, resulting in fewer low birth weight infants.

HANDS home visiting program evaluation of teen participants compared to similar non-participant teen mothers showed significnat decreases in LBW, and almost no VLBW when they started in the program in the first trimester. The program's efforts to decrease LBW births include: support

and follow-up for early entry into prenatal care, support for a medical home, provide information on smoking, secondhand smoke and pregnancy, nurse and social worker visits that focus on signs of premature labor, depression screening, and prenatal curriculum that focuses on nutrition, stages of fetal growth, exercise, expectations of infant, labor and delivery.

GIFTS (Giving Infants and Families Tobacco Free Starts) is a prenatal smoking cessation program that offers individualized counseling to pregnant women who smoke, have recently quit smoking in the previous 3 months, or are exposed to secondhand smoke. Currently, only women who receive services at the local health department within a nine county region in KY are eligible, regardless of payor source. Education and counseling is ultimately targeted toward smoking cessation, but a reduction in smoking is also encouraged. These women are educated on the both maternal and neonatal complications of prenatal smoking and exposure to secondhand smoke, such as low birth weight and prematurity.

Centering Pregnancy -- This group prenatal care model can result in improving low birth weight and other birth outcomes. In western KY, the UK Dental program is sponsoring Centering Pregnancy +Smiles, which has an oral health component. A second Centering Pregnancy program is at the Bluegrass High Risk Obstetrics Clinic at the University of Kentucky, which serves a large number of Hispanic mothers. Majority of the mothers who participated in this program were low-risk Hispanic women.

Federal Healthy Start Programs in Jeffferson County and Whitley county utilize home visiting an group strategies to address low birth weight in these high risk communities.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	7.6	4.2	6

Narrative:
The issue of infant mortality is a major focus of the Title V program.

KY has established two fetal infant mortality review projects in Kentucky. One in Louisville, which has the higheset concentration of African Americans in the state, and a second in Barren River, where there is a large hispanic population. The review teams in these areas provide more accurate data on fetal and infant deaths along with the identification of risk factors and potential prevention strategies. In addition, system barriers that may influence infant mortality may be identified and addressed by the community team members.

Also in Louisville, the DPH Office of Health Equity is studying contextual factors for Infant Mortality in some of the highest risk neighborhoods in the city.

KY is currently investigating the possibility of underreporting of infant deaths according to guidance from the National Center for Health Statistics. Review has begun on all live births with birth weights of less than 750 grams. It appears that there may be some infant deaths that do not have a registered death certificate and some births in which erroneous birth weights are

recorded. The MCH Division is collaborating with Vital Statistics to obtain accurate information 2006 through the current year.

The Kentucky Child Fatality Review Program follows the guidelines of the National Center for Child Death Review. The Kentucky State Child Death Review Team meets every other month and is organized to discuss and analyze data from a statewide perspective. The state review team is a multidisciplinary body from the community, and deaths that need further evaluation are brought before the state team for review. The state team provides technical assistance to existing local teams and facilitates the development of teams in counties that do not participate in the process. Additionally, the state team produces an annual report as required by legislation. Information on infant mortality in Kentucky can be found in the Kentucky Child Review Fatality Review System Annual Report which is submitted each year in November.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	60.1	76.3	71.2

Narrative:
This indicator dropped when KY changed to the new birth certificate for data collection. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. We are using a calculation recommended by the National Center for Health Statistics to determine early entry. Our epidemologist has completed a study of the two methodologies to see if the drop in KY's early entry after the change to the new birth certificate was related to the change in the way the data was collected. Most of the difference can be attributed to changes in reporting and not to changes in prenatal care utilization.

It is not surprising that this number is lower for Medicaid v.s. non-Medicaid. In our PRAMS pilot project (2008), about 15% of women reported not being able to access prenatal care as early as they wanted; the most frequent barrier cited was lack of a payor source/coverage for prenatal care. KY has presumptive elibibility for pregnant women, but it only covers them for 90 days, so many low income women delay getting prenatal care so that the 90 days will cover it thru the end of their pregancy if they turn out not to be Medicaid eligible.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	payment source from birth certificate	68.3	80	74.1

Narrative:
The calculation of this indicator changed in 2008. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. This could be a possible reason for the decline observed.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 19)	2009	150

(Age range to) (Age range to)		
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	200

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	185

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No

Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2011

Narrative:
Significant efforts in the past year have focused on the linkage of live birth certificate files with death certificates. A standardized linked file has been developed for calendar years 2006 through 2008. Staff will continue to focus on these linked files for more recent years as the live birth certificate files are closed by Vital Statistics. These files were used in the past months to assess whether Kentucky is underestimating the infant mortality rate. This question was raised based on the findings in the National Center for Health Statistics, Division of Vital Statistics Data Quality Report #1 that estimates the potential for 60 missing infant deaths in Kentucky in the less than 500 gram category. The 2006 linked birth-death dataset report also shows that states surrounding Kentucky to the South have the 10 highest infant mortality rates in the country while those states bordering Kentucky to the North are statistically higher than the national average. Kentucky's infant mortality rate, however, was reported as being at the national average.

A review of all live birth certificate data for Kentucky residents with birth weights of less than 750 grams was completed, and the linked birth death file was used to determine if a death certificate existed. Numerous infants were identified that probably were infant deaths without a corresponding death certificate. This data is being shared with Vital Statistics and recommendations have been made to determine accurate data for these records as well as to implement quality assurance efforts to minimize this occurrence in the future.

Linked birth-death files were created during this year for the calendar years 2006 through 2009. The 2008 and 2009 live birth certificate files have not yet been closed; however, they were included to begin quality assurance activities. A great deal of effort during this year has been on assessing the quality of this information.

Additionally, staff has utilized the linked birth-death files on a project to determine if all infant deaths are accounted for in the death certificate files. The SSDI Project Coordinator (Joyce Robl) and MCH Lead Epidemiologist (Tracey Jewell) reviewed live birth certificate data for all infants less than 750 grams in 2006 and 2007. The linked birth-death files were used to identify the infants in this weight category that had a death certificate. Data was also obtained from Medicaid and the Department for Community-Based Services to obtain information on deaths in those programs. This data was compared to infants that had no identified death certificate. These results have suggested that there are infants weighing less than 750 grams that are probable deaths for which there is no death certificate in the electronic file. Additionally, it suggests that the low birth weight rate may be inflated. The next step is to work with Vital Statistics staff to obtain clarification on the infants identified as probable deaths.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco Survey	3	No

Notes - 2011

Narrative:
Developed in 1992, the YRBS includes national, state and local school-based surveys of representative samples of 9th- through 12th-grade students. These surveys are conducted every two years, usually during the spring semester. The national survey, conducted by CDC, provides data representative of high school students in public and private schools in the United States. The state and local surveys, conducted by departments of health and education, provide data representative of public high school students in each state or local school district.
In Kentucky, the YRBS is given to a randomly selected sample of high school students. The data is reported as statewide totals only.

Ongoing efforts include Coordinated School Health and Kentucky ACTION (state tobacco control coalition) work to educate local school boards and site-based councils on the need for 24/7 tobacco-free schools and assist them in implementing comprehensive policies and revision of the PANTA (Physical Activity Nutrition Tobacco and Asthma) Guide to include the eight components of a Coordinated School Health Program. The Guide will be distributed to all Kentucky local health departments and schools.

Eight Regional Youth Tobacco Prevention Conferences have been held throughout the state of Kentucky in the fall and winter of 2009/2010. The local planning teams developed their own agenda based upon the expectations in a fall 2009 training which included the students bringing their schools' tobacco policies to the conference to be reviewed with an assessment tool. Example local planning participants include leaders from the local health department, family resource and youth services centers, Kentucky ASAP, Kentucky Cancer Program, universities, hospitals, faith-based groups, community coalitions, regional prevention centers and school staff. Approximately 811 youth and 175 adults (school sponsors, organizers) were in attendance. The youth are currently involved with their tobacco prevention activities of which will be reported this summer 2010 along with success stories.

The Kentucky Asthma Leadership team, supported by the CDC- DASH funding through the National Association of School Administrators and the National School Board Association has as one of the team objectives to assist school districts in providing a 24-7 or 100% tobacco free campus for their students, staff and visitors. The Kentucky Asthma Leadership team, CSH team and the Tobacco Prevention and Cessation Program conducted a survey of School District Health Coordinators concerning district's policies on tobacco. Through review of data gathered, materials have been developed (link to materials: http://www.site.kytobaccofreeschools.com/Resources.html) and a pilot informational meeting held on 24-7 tobacco free schools in Montgomery County Kentucky was held in April 2010. The purpose is to increase knowledge and awareness of model policies, practices and enforcement of 24-7 tobacco free schools.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Kentucky Department for Public Health is the organizational unit of Kentucky state government responsible for the development and administration of public health progorams and activities for the 4 million citizens of Kentcuky. Activities and programs fall within the traditional roles of public health - prevention, protection, and policy.

The Department for Pubic Health uses local health departments in all 120 counties as the main provider of direct services for public health programs. There are 57 administrative local health department units, some district health departments and some single county, but each of Kentucky's 120 counties have a local health department. These local health departments are not arms of the state health department, but are agencies of local county government, run by a local Board of Health and the County Judge-Executive. The state department for public health is charged with providing a single personnel system for the local health departments, and serves as the vehicle for distributing state general funds and federal grant funds to the local health departments. State health department staff provide program administration, such as training and protocol development to support the services that are delivered locally. This guidance is published in the Administrative Reference(AR) and Public Health Practice Reference (PHPR-clinical protocols). State public health staff are more directly involved in population based services such as newborn screening, and in infrastructure activities such as surveillance, needs assessment, evaluation, planning, standards development, and quality assurance. New progress in information technology is opening the door for new ways of assessing and delivering public health. Kentucky has already implemented a web-based system for electronic submission of both birth certificate data and newborn screening data in a single system at hospitals. An electronic dealth registry and immunization registry are being piloted this summer. Kentucky has also recevied a grant to implement a pilot Health Information Exchange in Lexington, which should also begin in 2010. Access to more timely and comprehensive data will allow for better data-driven decision making and public health improvements.

Of the activities for protection, DPH has had the most growth and improvement in emergency preparedness. Katrina in 2005 was the first big challenge for the systems that had been developed after 9/11. Kentucky responded well, sent several teams (enviromental teams covered there for months) and also received refugees from the disaster. All of this tested our systems and resulted in improvements. One was developing a network for health care workers to volunteer for such disasters, that Public Health can now access whenever surge capacity is needed. In winter 2008 Kentucky experienced the worst winter-time natural disaster in our history with a severe ice storm in western and central Kentucky. followed by flooding in western, then eastern Kentucky. CDC and other federal partners have been complementary of Kentucky's responses.

Policy is the foundation of improving public health, and DPH directs much effort towards not only developing model policies to address the major health problems of the state, but in gathering support for them through community coalitions, partners, and advocacy groups across the state. In most cases, local policy change is the first step in moving the state towards state-wide policy changes. However, in the current economic downturn, DPH and all parts of state and local government, are intensely examining what funding is available and how best to spend it. This in itself in a major policy decision. DPH is holding meetings with stakeholders, especially local health departments to determine what is core public health and prioritize which services are most essential to Kentuckians.

Thus, the 2010 MCH state-wide needs assessment is a timely review of what Kentucky's citizens think are the most important health problems in the state. As described in the Needs Assessment Document, the Department for Public Health utilized web-based provider survey, Community Forums, and Statewide Patient Survey as a means of obtaining input from our providers, patients, and communities. These efforts which began in 2008 and were conducted in 2009 have been

instrumental in determining the state priorities and new State Performance Measures. Both the Commission for Children with Special Health Care Needs and the Department for Public Health welcome questions from readers. Contact information for the main offices of both agencies are listed below. Upon receipt of your call, you will be connected to the appropriate staff.

Kentucky Department for Public Health, Division Maternal and Child Health 502-564-4830

Kentucky Commission for Children with Special Health Care Needs 502-595-4459

B. State Priorities

TITLE V 2010 PRIORITIES AND MEASURES FROM THE NEEDS ASSESSMENT

Priority 1. Reduce rates of substance abuse and smoking in pregnant women and teens.
The Title V program will not be able to take on this entire issue, but will continue to work closely with those agencies that do have this responsibility and bring focus on maternal and child health populations. DPH hosted state-wide community forums on tobacco in 2005 and now has 27 communities with tobacco-free ordinances. The cigarette tax in KY has been increased twice in the last 5 years in KY, but is still below the national average. The tobacco program has held youth advocacy programs around the state that have been very effective. This year's emphasis from the Tobacco Control program will be 24/7 tobacco-free school campuses. The Substance Abuse Division of Behavioral Health has a number of initiatives that we will work collaboratively with. To measure progress on these issues, Kentucky will rely upon:

a. NEW State Performance Measure #02: The percent of Kentucky High School students who smoked cigarettes on one or more days of the past 30 days. Source: YRBS and Youth Tobacco Survey. Since 90% of adult smokers take up smoking before the age of 18, this measure will allow us to target initiation of this risk behavior, which is often the precursor of other substance abuse behaviors.

b. NEW State Performance Measure #05: The percent of Kentucky residents age 12 through 17 who report illicit drug use in the last year. Source: YRBS Initiatives in the schools and policy level changes hold promise for reducing this number.

c. NPM # 15 -- Smoking in the third trimester of pregnancy. Source: Birth certificate data
Kentucky ranks next to worse on smoking in pregnancy, and has rates nearly twice the national average; one in four pregnant women in Kentucky continue smoking during pregnancy. Several initiatives are underway to address this issue, but to make a significant impact will require more than individual level interventions.

Priority 2. Reduce rates of obesity in maternal and child health populations in Kentucky, including children and youth with special health care needs.
KY has actively worked on obesity prevention since 2004 when DPH conducted state-wide forums in 11 sites. From these came a state plan, a state-wide coalition, the Partnership for a Fit KY, and local community coalitions at the 11 sites. KY in 2006 passed one of the strongest school nutrition bills in the country. Mandatory physical activity for schools has been proposed but not yet enacted. Recent efforts are focusing on policy change, including farms to schools, built environment, and child care policies. Pediatric obesity is a priority for CHFS Secretary Miller and Commissioner Hacker. DPH collaboratively funds local health departments through the preventative services block grant, MCH block grant (medical nutrition therapy), and Healthy Communities grants for local initiatives to combat obesity. KY AAP received a grant from Robert Wood Johnson to hold Advocacy trainings on Pediatric Obesity, and has also developed an office toolkit to address the issue. Contextual factors in Kentucky, including high rates of poverty and geographic isolation in rural areas make the challenge particularly big for Kentucky. Obesity is a particularly important issue for CYSHCN, hence the need for a specific State Performance

Measure for this population. However for both agencies and among all the groups participating in the 2010 Needs Assessment process, there is a high degree of concern which should translate to a bias toward action. Grassroots activities are increasing. Policy level approaches are also under development.

Measures for tracking progress will include:

a. NEW State Performance Measure #01: The percentage of first time births to Kentucky resident women age 18 and older who had pre-pregnancy BMI's in the overweight or obese categories. Source: Kentucky Birth Certificate Files. This measure is a reflection of preconception care, as well as increased risk for the pregnancy, as obesity is more and more associated with adverse birth and delivery outcomes.

b. NEW State Performance Measure #07: Increased percent of children served by Kentucky CCSHCN with BMI at healthy weight (between 5th and 85th percentile). Source: CCSHCN CUP (Patient Health Information System).

c. NPM #11 -- The percent of mothers who breastfeed their infants at 6 months of age. Breastfeeding is a first line of protection against developing obesity later in life.

d. NPM #14: The percentage of 2 -- 5 year olds with greater than 85th percentile BMI. In many cases, children are already obese before they get to school age. This measure allows us to target and track low-income children in early childhood where there are more opportunities for true prevention and addressing lifestyles.

d. Children and youth overweight and obesity will still be monitored from existing sources, but not used as a measure of progress for the block grant. Numerous initiatives targeting school age children and school policies are underway in Kentucky to address this population.

Priority 3. Reduce the rates of births to teen mothers in Kentucky. One of the top three topics in nearly every part of the Needs Assessment, teen pregnancy is a serious concern for communities all across the Commonwealth. It is also a symptom of the issues underlying not only teen pregnancy, but also substance abuse, smoking, suicide, and other mental and physical health issues in the teen population. Efforts around this need will be lead by the Adolescent Health coordinator in the Division of Women's Health, who currently works closely with the Title V MCH program. A stakeholder group has been meeting for several months (since the forums), focus groups with teens have been completed, and a multidisciplinary stakeholder group is developing a state plan for action.
Since teen pregnancy is addressed in a current NMP, Kentucky will monitor progress using that measure:

a. NMP # 8: The rate of births (per 1000) for teens ages 15 through 17. Data Source: Kentucky Birth Certificate Files

Priority 4. Reduce the number of Kentucky children dying from child abuse or maltreatment. Deaths from child abuse and maltreatment are exceedingly tragic, and children are especially vulnerable at age less than 5. Kentucky currently leads the nation in child abuse deaths, increasing the urgency of this need.
In collaboration with the Division of Protection and Permanency, MCH is engaging in more discussion of how to address this need on a number of fronts. The first barrier is collecting accurate and complete data, as there is no common definition of child abuse and it rarely is listed as a cause of death on death certificates. In addition, most programs to "prevent" child abuse are secondary prevention, targeted at recognizing the signs after the child abuse has occurred. Kentucky is also now exploring evidence-based primary prevention programs such as Triple P.

a. NEW State Performance Measure #04: The proportion of Kentucky children birth to 5 years of

age who die from child abuse. Data Source: Protection and Permanency Child Fatality Review data files.
b. National Health Outcome Measure (NOM) # 06: The child death rate per 100,000 children aged 1 through 14.

Priority 5. Decrease the Infant Mortality Rate and eliminate the disparities in Infant Mortality in Kentucky. Preterm birth is one of the three leading causes of infant mortality, and the only cause that has been increasing in the last decade. Since the Surgeon General's Conference on the Prevention of Preterm Birth in 2008, it has been recognized that contextual factors and social determinants of health play as important a role in preterm birth as medical risk factors.

Kentucky has a project studying the contextual factors relating to preterm birth in Louisville, KY, in neighborhoods with high populations of African-Americans live. In addition, the Appalachian area is a disparate population with high concentrations of poverty and similar contextual factors. The other focus of prematurity prevention for Kentucky is the Late Preterm Births, those occurring between 34 0/7 weeks and 36 6/7 weeks gestation. Kentucky's Healthy Babies are Worth the Wait initiative, with March of Dimes and Johnson and Johnson, has been recognized nationally for emphasizing strategies to address late preterm births as a population at risk and potentially preventable preterm birth.
Progress on these efforts will be measured by:

a. NEW State Performance Measure #03: Percent of singleton live births to Kentucky residents that are 34-36 weeks (late preterm) at delivery. Data Source: Kentucky Birth Certificate Files

b. NPM #17: Percent of Very Low Birth Weight Infants delivered at facilities for high risk deliveries and neonates

c. National Health Outcome Measures #01 through #05 -- infant mortality, black/white infant mortality ratio, neonatal mortality, post-neonatal mortality, and perinatal mortality rates.

d. Health Systems Capacity Indicators # 05 A, B, C, and D, covering low birth weight, early and adequate prenatal care, and infant mortality by Medicaid vs. non-Medicaid

Priority 6. Improve the Oral Health Status of Kentucky's children, youth, and pregnant mothers. Improving oral health in Kentucky is one of the major access to care issues in the state, as there are few dentists in rural areas, fewer pediatric dentists, and many dentists even in urban areas who do not accept Medicaid patients due to low reimbursement. In addition, there are cultural barriers, as many families accept poor oral health as the norm.

Kentucky will measure progress on this need by:

a. NPM # 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

b. Health System Capacity Indicator #07A: Percent of Medicaid eligible children ages 6-9 who received a dental service

c. State Performance Measure #06 (continuation): Percent of Medicaid-covered women who received at least one dental visit during their pregnancy.

Priority 7. Improve transition services for CYSHCN. As reported earlier 82% of CYSHCN report having received no transition services. When adjusted for age and semantics, many more do report having actually received these services (28-56%, depending on the element), and the CCSHCN cohort does report a significantly higher frequency of services than the non-CCSHCN cohort however, this area is targeted for improvement over the next five years.

a. NEW State Performance Measure #08: Percent to which CCSHCN transition action plan is implemented. Source: CCSHCN CUP (Patient Health Information System).

b. NPM #06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
Through this process, CCSHCN utilized staff of the Healthy and Ready to Work National Resource Center to provide a national perspective on SPMs in designing the transition measure with an eye towards developing infrastructure. Using Hawaii's SPM as a model, CCHSCN has developed its own transition action plan as detailed in the Needs Assessment document.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96	98	98	99	99.2
Annual Indicator	98.4	98.5	97.6	98.6	99.2
Numerator	380	534	526	725	860
Denominator	386	542	539	735	867
Data Source				KY Newborn Screening Database	KY Newborn Screening Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.5	99.5	99.5	99.6	99.6

Notes - 2009
2009 data is preliminary and numbers could change.

a. Last Year's Accomplishments
KRS 214.155 requires that all Kentucky birthing hospitals perform mandated quality assurance tasks to ensure that every infant born at their facility receives the metabolic newborn screen.

902 KAR 4:030 mandates that all infants born in the state of Kentucky receive the metabolic newborn screening test except those parents seeking religious exemption. In 2009, religious exemptions were very minimal at a rate of approximately five (5) per year. Parent educational materials were modified to be more ‘parent friendly' and less technical.

902 KAR 4:030 mandates that all Kentucky birthing hospitals assign a newborn screening coordinator to perform mandated quality assurance tasks to ensure that every infant born at their

facility receives the metabolic newborn screen.

In 2009, NBS staff continued working with hospitals in development and implementation of the quality assurance process mandated by state regulation. NBS developed a protocol template to assist them in developing their own plan with greater ease. Approximately twenty percent (20%) of all Kentucky birthing hospitals are compliant in updating their quality assurance plan in 2009. This will remain a focus of the NBS program throughout 2010.

Collaboration with birthing hospitals continues in the analysis of the timeliness of both specimen collection and submission to the state lab for testing. Time of specimen collection to receipt by the state lab was evaluated and NBS staff worked with facilities whose submissions where greater than seven (7) days to improve their collection and mailing processes. Analysis of the 2009 data for timeliness from specimen collection to receipt of specimen showed that the 2009 average is 4.58 days. Preliminary 2010 data equaled 4.48 days showing improvement in the overall process.

NBS staff also assisted facilities in the quality assurance process by tracking possible missed newborn screening tests not received by the state lab. A report is generated by the lab system of specimens that hospitals record as collected but never received at the state lab. The Vital Statistics system also generates a report of birth certificates documenting those with no screen collected. Any discrepancies found in these reports are investigated by contacting the specific birthing hospital for tracking and resolution.

In 2009, NBS continued participating as part of the Region 4 Genetics Collaborative in development of a database designed as a resource in establishing treatment protocols and producing a care notebook for parents of diagnosed infants.

The Kentucky State Lab developed and tested a web-based physician-accessible information system in 2009 to enable healthcare providers across the state to access and print newborn screening results on their patients. This process is continuing with full implementation scheduled in 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Newborn Screening program was expanded to a total of 49 disorders with the addition of 20 secondary conditions.			X	X
2. Enhancements made to the newborn screening data system to allow interfacing with the vital statistics electronic birth certificate at birthing hospitals using a bar code.			X	X
3. Laboratory Information system implemented to allow for scanning bar-coded labels into the lab system, automatically laoding the demographic information directly from the KY-CHILD system.			X	X
4. Educational trainings for providers on newborn screening and specimen collections have been updated and are available online.			X	X
5. Contracted with univeristy metabolic specialists for consultation related to metabolic conditions		X	X	
6. Provide payment system for metabolic foods and formula for affected infants without a payor source	X	X		
7. Cooridnate follow up of positive screens with university specialists, local providers, and families		X	X	X

8. Participate in Region IV Collaborative on Newborn Screening to develop common protocols for addressing rare disorders			X	X
9. Integrate Region IV NBS data into Kentucky Birth Surveillance Registry			X	X
10.				

b. Current Activities
The state laboratory purchased the necessary equipment to begin performing second tier tests for Cystic Fibrosis to include DNA testing on the presumptive positive screens. The program maintains updated informational fact sheets and resources on the newborn screening disorders, one for health care providers and one for parents. These education materials were also made available on the website http://chfs.ky.gov/dph/mch/ecd/newbornscreening.htm.

Kentucky participates in a HRSA Regional Genetic and NBCollaborative Grant in Region 4. Infants diagnosed as positive for disease are being fully integrated into the birth defect registry for long term tracking. Kentucky continues to participate in the initiatives of this grant.

KBSR received a new CDC Grant in 2010 to expand surveillance and integrate positively identified infants into both the KBSR system for long-term tracking and for referral to early intervention services.

KY continues to provide education to reduce the number of refused NB screens; in assisting hospitals develop comprehensive NB screening protocols to decrease the occurrence of babies being discharged without NB screening collected; improving time of specimen collection to submission to laboratory for testing; continues participating in HRSA Region 4 projects; and continues to develop methods for referring newly diagnosed infants to early intervention services for evaluation.

c. Plan for the Coming Year
Implementation of web-based access for physicians to newborn screening results will be implemented this year.

A copy of each hospital's NBS protocol will be collected and reviewed on an annual basis. If the submitted protocol is determined inadequate, NBS will work with the hospital in developing a quality process to assure that all babies born at their facility receive a newborn screen before hospital discharge.

NBS will identify hospitals experiencing excessive delays between the time of NBS collection until arrival of specimen to the State Lab. NBS will establish baselines for each hospital, send them a report of their activity on a quarterly basis, and work with them on improving their process.

A NBS disaster/emergency protocol will be finalized with all NBS partners for the continuation of newborn screening testing from hospital to laboratory to NBS follow-up, specialists, primary care physicians, the U.S. postal service, back-up laboratories, law enforcement agencies including the national guard, and by establishing lab values considered critical warranting encompassing collaboration.

Monthly, quarterly, and annual reports will be simplified to improve accuracy and time management for internal and laboratory staff.

A 5-year report will be developed showing the number of infants diagnosed and how many were identified via the newborn screening expansion.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**55140**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	54749	99.3	8	4	4	100.0
Congenital Hypothyroidism (Classical)	54749	99.3	285	42	42	100.0
Galactosemia (Classical)	54749	99.3	84	3	3	100.0
Sickle Cell Disease	54749	99.3	10	6	6	100.0
Biotinidase Deficiency	54749	99.3	58	21	21	100.0
Congenital Adrenal Hyperplasia	54749	99.3	52	4	4	100.0
Cystic Fibrosis	54749	99.3	199	25	25	100.0
Homocystinuria	54749	99.3	4	0	0	
Tyrosinemia Type I	54749	99.3	5	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	54749	99.3	7	3	3	100.0
Tyrosinemia Type II	54749	99.3	3	0	0	
Argininemia	54749	99.3	1	0	0	
Argininosuccinic Acidemia	54749	99.3	1	1	1	100.0
Citrullinemia	54749	99.3	3	0	0	
Isovaleric Acidemia	54749	99.3	10	2	2	100.0
Carnitine Uptake Defect	54749	99.3	11	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	54749	99.3	7	0	0	
Methylmalonic acidemia (Cbl A,B)	54749	99.3	3	1	1	100.0
Glutaric Acidemia Type I	54749	99.3	4	1	1	100.0
Medium-Chain Acyl-CoA	54749	99.3	24	14	14	100.0

Dehydrogenase Deficiency						
Methylmalonic Acidemia (Mutase Deficiency)	54749	99.3	2	0	0	
Short-Chain Acyl-CoA Dehydrogenase Deficiency	54749	99.3	9	4	4	100.0
Carnitine palmitoyl transferase deficiency type II	54749	99.3	1	1	1	100.0
Hemoglobin Sickle C Disease	54749	99.3	28	1	1	100.0
Hemoglobin S-Beta Thalassemia	54749	99.3	2	1	1	100.0
Variant Hemoglobinopathies	54749	99.3	43	7	7	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	67	67	68	69
Annual Indicator	65.1	69.3	64.1	62.5	87.8
Numerator	5560	6141	5261	3999	431
Denominator	8543	8862	8206	6398	491
Data Source				CCSHCN Database (FY 08)	CCSHCN Family/Consumer Survey #11 & 11a
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	91	91	91	91	91

Notes - 2009
2009 Data from CCSHCN Needs Assessment Consumer/Family Survey - average of 2 separate questions addressing satisfaction and partnership in making decisions. Responses filtered to CCSHCN respondents.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008. Age group used for

this PM is 3-18 as KY utililzes transition checklist information for the numerator; and the transition checklist is primarily completed for children age 3 and older.

The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
As part of the Needs Assessment process, a wide-ranging survey was initiated during the reporting period, yielding 934 responses, including 497 families enrolled in the Commission for Special Health Care Needs (CCHSCN) programs. Findings include:

•91% satisfaction with overall care among CCSHCN families, including 70% who were "very satisfied"; and
•79% of CCSHCN families responded that my doctor "always" includes them in making decisions, while an additional 18% responded "sometimes".

As with the Needs Assessment survey, CCSHCN processes are intentionally designed to make a concerted effort to solicit stakeholder feedback, and to improve operations based on the communication received. Members of the CCSHCN Youth Advisory Council (YAC) and Parent Advisory Council (PAC) provided valuable input on a quarterly basis, which was evident during the Needs Assessment development process, and can be seen as partially responsible for the high survey response rate.

CCSHCN secured a Family to Family Health Information Center (F2F) grant, the intention of which is to build the capacity of the parent/family network. In addition to the original grant, the Kentucky Infants Sound Start program was awarded additional funding to support the same for children with hearing loss. Building on an existing network of family advocates in partnership with the state-wide network of Title V CYSHCN services, the new centers are directed by parents of CYSHCN who also have experience with federal and state, public and private health care systems and providers. Information, education, technical assistance and peer support are made accessible to families through these efforts. The intention is to improve the family's experience and satisfaction, while at the same time providing a support network to help families navigate the options for services needed for their children. Financial support is available to support parents via stipends.

Working with the PAC, CCSHCN developed the documents and forms for F2F, to ensure that the information given is understandable and written from a family perspective.

CCSHCN staff attended Parent Leaders Training through the Kentucky Partnership for Families and Children, which both increased staff knowledge about children with mental health issues and assisted in a partnership which yielded several new support parents for F2F.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parent Advisory Council meets regularly and open to all KY parents of CSHCN. Transportation expenses are reimbursed.		X		X

2. Youth Advisory Council meets regularly and open to all KY CYSHCN. Transportation expenses are reimbursed.		X		X
3. CCSHCN acts under the advisement of a Board of Commissioners, as well as several program specific advisory boards.		X		X
4. CCSHCN employs parents of CSHCN as family consultants.		X		
5. Interpreters are available for families of children who are limited in English proficiency and enrolled in CCSHCN services during clinic and non-clinic appointments.				
6. Information about CCSHCN and CSHCN services are available on the CCSHCN website (in English and Spanish)	X	X	X	X
7. CCSHCN clinic mini-survey to measure satisfaction and other key elements of services		X		X
8.				
9.				
10.				

b. Current Activities

CCSHCN implemented another avenue of communication to measure and monitor family satisfaction by initiating a structured comment card protocol in all clinics. This effort should supplement the consumer comment line which is printed on all clinic home instruction sheets. To date, 311 responses have already been received, and the satisfaction rate is 97%.

CCSHCN looks to its Board of Directors, PAC, and YAC for advice and consent regarding the concerns of the special needs population. Board members represent parents of a special needs child(ren) and/or practitioners with extensive expertise treating and/or working with the special needs population, including early intervention, the KY Deaf-Blind Project, and a protection/advocacy program for the disabled. Such diversity allows CCSHCN to receive feedback from a variety of external sources regarding public perspective of CCSHCN programs.
Current F2F activities include:
•Recruiting and training local and regional support parents;
•Matching parents to support parents;
•Developing systems for support parents to input data and research resources and materials for families;
•Identifying and implementing regional training needs for each office;
Current CCSHCN activities involving the PAC include:
•Continuing to advise the PAC on legislative processes and informing them of funding issues or bills that affect CYSHCN; and
•Conducting sessions for parents about advocacy related to their children's needs.

c. Plan for the Coming Year

CCSHCN looks forward to maintaining the efforts mentioned above, particularly with regard to the continued implementation of F2F. Those plans include initiating "impact calls" to families to identify the level of satisfaction with services and working on the comment card initiative.

With the input of the YAC and PAC, CCSHCN staff is in process of developing a transition survey for youth who receive CCSHCN services. CCSHCN will continue to seek input from both the PAC and YAC on operations and policy in order to improve family satisfaction with our services.

Based on survey responses, CCSHCN will be working to improve scheduling methods and expand on methods of communication and outreach.

F2F activities include:

•Recruiting and training support parents and regional support parents;
•Matching parents to support parents;
•Developing systems for support parents to input data and research resources and materials for families;
•Identifying and implementing regional training needs for each office;

CCSHCN activities involving the PAC include:
•Continuing to advise the PAC on legislative processes and informing them of funding issues or bills that affect CYSHCN; and
•Conducting sessions for parents about advocacy related to their children's needs.

YAC activities include:
•Developing an article about lessons learned by college students with disabilities for "Kentucky Transition News", a mulit-agency collaborative;
•Providing input into development of CCSHCN's new transition survey initiative; and
•Hosting guest speakers, such as representatives from the Center for Accessible Living and experts on driving with adaptive equipment.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	92	93	93
Annual Indicator	90.1	90.0	91.3	92.0	91.9
Numerator	7699	7976	7618	7724	7320
Denominator	8543	8862	8343	8393	7964
Data Source				CCSHCN Database (FY 08)	CCSHCN CUP Information System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94	94	95	95	95

Notes - 2009
Data derived from CCSHCN CUP information system

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

The Medical Home for Coordinated Pediatrics (MHCP), a collaboration with the University of Kentucky and housed in the Lexington CCSHCN office, continues to provide primary care and care coordination for children involved with Kentucky's child welfare system. Enrollment during the reporting period increased significantly, to double its previous enrollment.

Selected CCSHCN leadership and staff attended and participated in a number of conferences and meetings with the intent of improving the working knowledge of staff on the latest concepts about the medical home. The annual AMCHP conference was a great resource and time was spent focusing attention on these specific sessions. The CCSHCN parent liaisons also brought back information from the Region 4 Genetic Collaborative regarding the medical home approach and presented it to the CCSHCN program coordinators and other staff.

A survey was used to evaluate staff's knowledge of the key concepts of a medical home. Staff respondents reported a high level of understanding. A survey was conducted for CCSHCN consumers and families with children with special health care needs and 2/3 of all respondents report that the concept is new to them.

The western region Family to Family (F2F) Health Information Center co-director participates with our Region 4 Genetics Collaborative which has a core mission to assure that CYSHCN receive care in a medical home environment. Through collaboration with Region 4, informational handouts and guides have been obtained and incorporated in the F2F family consultants' educational resources to ensure families become familiar with the principles of the medical home. CYSHCN families are informed that a medical home offers accessible, continuous, comprehensive, coordinated, compassionate, culturally effective, family centered care. Tip sheets are available to provide guidance regarding choosing and working with a doctor, preparing for and participating in a doctor appointment, what care coordination and culturally effective care look like, as well as continuous care while transitioning to adult care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Primary care physicians are identified for each child and documented in database.				X
2. CCSHCN provides medical specialty care in collaboration with child's medical home.	X			
3. Children are able to see multiple specialists in one visit to clinic.	X			
4. The Foster Care Support Branch collaboration with DCBS allows for the coordination of medical services for children in the foster care system.	X	X		
5. The Medical Home for Coordinated Pediatrics in Lexington provides primary care for children in the foster care system who do not otherwise have a primary care physician.	X	X		
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Twelve CCSHCN offices throughout the state continue to provide on-site multidisciplinary specialty clinics. CCSHCN strives to ensure that all patients are active with a primary care physician by verifying that primary care services are received at each clinic encounter. If primary care is not identified the clinical staff attempts to connect the family with an appropriate provider within its community. Specialty clinic dictation and medical plans of care are shared with the patient's primary care physician in accordance with HIPAA guidelines after each clinic visit. CCSHCN registered nurses and social workers provide comprehensive care coordination, education, and developmentally appropriate transition services mindful of lifelong health and uninterrupted services into adulthood.

The foster care program continues to collaborate with DCBS to ensure that ongoing, preventative health services are addressed for the foster care population. Recently, standards of practice and forms were modified so that nurse consultants are prompted to communicate with social service workers about the need for a medical home on all encounters completed.

c. Plan for the Coming Year
The information presented at the AMCHP Conference regarding the seven principles of a medical home will be a guide to future planning for staff, patient, and family education.

CCSHCN is in the process of identifying gaps and developing processes to ensure every patient is receiving services from an adult health care provider by age 18. Staff is currently developing an assessment tool that will focus on our youth ages 14, 16, and 18 years to assure a continuous comprehensive system of health care. Each patient will receive a birthday letter at age 14, 16 and 18 that will discuss future needs and offer the opportunity to work with the care coordinator to find services and smooth the transition into adult care systems. A questionnaire will be attached that identifies the patient and families progress toward this transition.

Discussion has been initiated with CCSHCN's Medical Director to determine if physicians are receiving information regarding the medical home concept. A method will need to be determined for future planning that will focus on the need for education and outreach to community providers and other partners to understand how accepted this concept has become and what barriers exist. CCSHCN can then explore its role as a community partner in filling gaps regarding the principles that provide CYSHCN a medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	65	93	93	99	99
Annual Indicator	91.0	89.8	92.4	90.9	93.1
Numerator	7778	7962	8125	7626	7417
Denominator	8543	8862	8791	8393	7964
Data Source				CCSHCN Annual Report for FY 08 and CCSHCN	CUP Database

				Database	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN Annual Report for FY 2007-2008 (numerator) and CCSHCN Database (denominator). Age group used for this PM is 0-21 as previous year information is not available in 0-18 sub-group for numerator.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN Annual Report for FY 2007-2008 (numerator) and CCSHCN Database (denominator). Age group used for this PM is 0-21 as previous year information is not available in 0-18 sub-group for numerator.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
CCSHCN's strong emphasis on getting clients insured during the reporting year came out of the need to control expenditures to meet the demands of decreasing budgets. CCSHCN began a new process of proactively checking for insurance coverage on all patients for all services delivered 3-7 days prior to service delivery. This has given the CCSHCN the opportunity to detect and address all situations where insurance has been lost and follow up with assistance to families in finding alternate coverage in a more timely fashion. This new system has resulted in a drastic reduction in the uninsured rate at time of visit by 50%.

Through targeted advocacy, the CCSHCN has also had success on other fronts. Staff have been successful in obtaining public assistance for several special-circumstance clients who would otherwise not have been eligible. Compassionate factor programs have been utilized to support the factor needs of hemophilia patients. Increased proficiency in the insurance appeals process has been successful with regard to therapy and hearing aids patients. (CCSHCN has the benefit of a recently-passed state law requiring Kentucky-based insurance plans to cover hearing aids.)

With regard to underinsurance, CCSHCN has had to reduce assistance with co-insurance and deductibles, by approximately $800,000. While the effort was initiated for the agency's financial benefit, the result was also a better understanding on the part of staff about how patient needs can be met in a more efficient manner using other outside resources and programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. CCSHCN staff document and the insurance status in the electronic data system.				X
2. CCSHCN educates families about their insurance coverage and seeks additional sources of payment for services for which the family may qualify.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
While continuing the efforts of ensuring insurance coverage for all patients mentioned above, CCHSCN continues to remain vigilant for those who are underinsured by contacting available resources to make sure that their needs are met. To this end, a resource guide has been developed for use by staff and is posted on the agency intranet.

CCSHCN continues to contract with Patient Services Inc. (PSI) for the provision of insurance case management for those without or at risk of losing their insurance coverage.

c. Plan for the Coming Year
Like so many other agencies, CCSHCN eagerly awaits the impact of the implementation of the recent federal legislation preventing insurance companies from covering children under the age of 19 for pre-existing conditions, as well as health care reform in general.

CCSHCN plans on maintaining uninsured numbers at the current low levels and will take advantage of any new and positive changes that become available to the uninsured and underinsured CSHCN population through education and assistance with navigation through the system. While working to meet the needs of the residual uninsured population, CCSHCN will also look to expand services to reach CYSHCN who are not being served and identify opportunities to do such.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	93	93	93	96
Annual Indicator	91.1	89.8	92.9	95.5	95.9
Numerator	7781	7961	7749	7928	7558
Denominator	8543	8862	8343	8304	7880
Data Source				CCSHCN Database (FY 08)	CCSHCN CUP Information System
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	97	97	98	98	98

Notes - 2009
Data derived from CCSHCN CUP information system.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
CCSHCN's family survey in conjunction with the Needs Assessment revealed that 85% of CCSHCN respondents reported no difficulty accessing or using community resources, compared to 51% of non-CCSHCN respondents. CCSHCN feels that these findings are encouraging and is confident about the system of care. However, families feel that it is sometimes a challenge to access services outside of CCSHCN's purview.

A staff resource guide was developed and is posted on the agency intranet for all staff to use.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Families with children who require services from multiple specialists were scheduled to see multiple providers in one clinic visit.	X			
2. CCSHCN employs two parent consultants who educate families in the navigation of community-based service systems.		X	X	
3. CCSHCN staff partner with and participate on advisory boards and councils which are community-based, i.e. Regional Interagency Transition Team and First Steps.		X	X	
4. CCSHCN staff attend community organized events statewide to promote and distribute information about the agency and its services.		X	X	
5. CCSHCN offers materials in other languages, as well as seeks out resources for families that are culturally competent.		X	X	X
6. The CCSHCN utilizes a voice mail system with a separate voice mailbox with information in Spanish. Staff with the Cabinet for Health and Family Services translate the messages for staff.		X	X	
7. CCSHCN provides consultative nursing services to the		X		

Department for Community Based Services social work staff for children in the foster care system.				
8.				
9.				
10.				

b. Current Activities

The Family to Family (F2F) program is a vital new aspect to infrastructure for CSHCN in Kentucky, pairing parent mentors with families of CSHCN. F2F creates opportunities for one on one mentoring, so families can improve their ability to access services and supports, be more self-assured as they participate in decision-making, and make informed choices about health care that promote good treatment decisions that are cost effective and improve health outcomes for their children throughout their lives. F2F also provides accurate, up to date information regarding health care needs and resources available for CSHCN. The families are trained on how community based services are organized and how to use them. F2F also assists families who are interested in improving the delivery of services and how they can effectively advocate for needed changes.

CCSHCN social workers assist clients in brokering resources and the network of contracted service providers numbers almost 1000. CCSHCN communicates with families to determine areas of disorganization in community-based systems; and assist families with the navigation of those systems.

Children who require services from a multi-disciplinary team are scheduled to see multiple specialists in one visit to improve communication by creating a unified plan of care that is communicated and agreed upon by all the members of team. This methodology also reduces stress by minimizing school absences and other disruption to the family's routine.

c. Plan for the Coming Year

As a state agency with an 85 year history of service provision, CCSHCN has developed formal and working relationships with a variety of programs providing services to children, however there are always new players in the field. The CCSHCN will strives to remain connected and relevant by remaining involved with outside organizations that are resources to families of CYSHCN. The staff will continue to seek out and develop partnerships with a variety of community leaders and agencies to improve transparency in the delivery of community based services, reduce duplication and streamline the process of accessing community resources.

CCSHCN staff will continue to serve and be active on a wide variety of boards and councils that further the agency's mission. Particularly visible collaborations include Medicaid; child welfare; education; and the Home of the Innocents (HOTI), a private child caring facility; with which CCSHCN and HOTI share a Medical Director, and Louisville CCSHCN therapy staff (PT, OT, and SLP) are housed at the private child caring facility and have access to state-of-the-art equipment. The CCSHCN hopes to strengthen its boundaries by continuing to develop and cultivate partnerships such as those mentioned above. A stronger emphasis is planned on outreach, and educating other agencies on CCSHCN mission and processes.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	51	52	53	30	53
Annual Indicator	9.6	9.7	55.4	62.4	61.0
Numerator	821	859	897	902	831
Denominator	8543	8862	1618	1445	1362
Data Source				CCSHCN Database (FY 08)	CCSHCN CUP Information System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	54	54	55	55	60

Notes - 2009
Data derived from CCSHCN CUP information system.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Actual data derived from KY CCSHCN database for FY 2007-2008. Age group queried for this PM has been changed to 14-18. The data set queried for the numerator pertains to transition information that the CCSHCN primarily obtains beginning at the age of 14. The denominator data set has also been changed to the age group of 14-18. This will provide a better representation of the age group which is targeted for transition services for adulthood.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
CCSHCN staff continue to utilize the Transition Checklist and document transition information in the electronic data system. Transition services are integrated as part of ongoing practice and addressed through one-on-one discussions with families enrolled in CCSHCN programs, and by collaborating with community partners and encouraging participation from all members of the special needs community. During the past year, CCSHCN engaged in an open and frank discussion about how to get a better read on transition numbers and how to measure success accurately. Clinic mini-surveys were initiated and will form part of the measurement in the next reporting period.

As they have in previous years, transition services continue to represent an elusive goal, despite years of efforts to incorporate transition planning into practice. Responses on staff surveys reflect an understanding of the basics of transitions and agency policy requiring services, yet client surveys received and the Youth Advisory Council focus groups indicated that the information is not recognized by families as "transition services". Whether semantic or not (many parents are

not familiar with the term "transitions" but do report receiving elements of these services when asked in different language not using the phrase), 82% of children and youth with special health care needs (CYSHCN) report having received no transition services. When adjusted for age and semantics, many more do report having actually received these services (28-56%, depending on element), and the CCSHCN cohort does report a significantly higher frequency of services than the non-CCSHCN cohort; however, the numbers are much too low to consider efforts a success. CCSHCN has seen fit to prioritize this in the next 5-year cycle through an additional SPM (more thoroughly discussed elsewhere in this report). Meanwhile, in addition to increased efforts which are planned, CCSHCN continued in the reporting year to educate families on the expectations they should have for their child's transition into adult life and remained actively involved and connected with a variety of transition collaborations, including:

•Kentucky Interagency Transition Council for Persons with Disabilities and the 11 Regional Interagency Transition Teams (RITTs) across the state. Examples of RITT activities include: participating in transition/family exhibit information fairs, and Disability Mentoring Day activities;
•Kentucky Statewide Council for Vocational Rehabilitation, of which CCSHCN staff currently serves as chair;
•Center for Accessible Living, an important link for transitioning youth to post-secondary education, work and independence; and
•Participation in several Job/Transition fairs through state special education cooperatives and other education support groups (such as Family Resource/Youth Service Centers) and RITTs, in which high school youths with disabilities were able to participate in mock interviews and learn to prepare resumes and cover letters.

Significantly, CCSHCN was awarded HRSA grant funding to develop a KY Family to Family (F2F) Health Information Center. F2F builds on an existing network of family advocates in partnership with a statewide network of Title V CYSHCN to promote better access to health care for CYSHCN, including transition services. During the reporting year, F2F activities included beginning to organize and generating modules with which to train support parents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CCSHCN staff utilize and update Transition Checklist. Information is documented in electronic data system. Items on checklist identify readiness to transition to adult life, including ability to perform activities of daily living, insurance coverage.		X		X
2. CCSHCN provides training and planning resources to members of the Youth Advisory Council; and solicits ideas for training needs.		X		X
3. CCSHCN provides training and planning resources to members of the Parent Advisory Council; and solicits ideas for training needs.		X		X
4. CCSHCN partners with other federal and state organizations which educate and support youth and adults in the transition process, such as the Healthy and Ready to Work program, Vocational Rehabilitation and Center for Accessible Living.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

•CCSHCN has initiated the clinic mini-survey (comment cards) initiative, to measure, on an ongoing basis, information from clients on the receipt of services, including aspects of transitions. Efforts continue, and by the next reporting period, over a year's worth of data will have been compiled and assessed.
•F2F continues to expand the number of support parents. To date, F2F has worked with families on 14 transitions outcomes issues.
•PAC and YAC continue to be asked for input on transition planning.
•CCSHCN is working with the YAC stakeholders to problem-solve the identified dissatisfaction with referrals made to the Office of Vocational Rehabilitation. There are a number of reported issues which include the timing of referrals, difficulty navigating through the system, extremely long waiting periods for approval of services and limitations on the numbers served which has resulted in priority lists based on level of need.

c. Plan for the Coming Year

Further focus is planned in the area of transitions, within the coming year. The evaluation of several new sources of data continues, although CCSHCN is ready to move to action to become more effective in this priority area. A team has been assembled under the direction of the Director of Nursing which will be analyzing the clinic process and recommending methods for integrating transitions discussions more effectively into that environment. They will also be initiating phone calls and new tools to improve interventions and suggest new ones, as needed. Highlights include:

•The initiation of age-specific transition letters to all CCHSCN-enrolled youth on their 14th, 16th, and 18th birthdays to bring attention to key issues, engage youth in prioritizing their own interests and concerns, develop a road map to success and provide information about how to implement the plan;
•An increased presence of the central office transitions coordinator by personally meeting with every Louisville patient ages 18-21;
•Performance of an assessment to determine how to align staff practices for the most effective delivery of transition services; and
•The inclusion of a transitions section on a planned Nursing Care Plan for each CCSHCN-enrolled child.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	92	92	86	86
Annual Indicator	79.7	84	80.9	76.8	76.8
Numerator					
Denominator					
Data Source				CDC's NIP Survey	CDC's NIP Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	88	90	90	92

Notes - 2009
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data reflects year 2008, the 2009 data will not be available until sometime next year.

Notes - 2008
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data reflects year 2007, the 2008 data will not be available until sometime next year.

Notes - 2007
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data reflects year 2006, the 2007 data will not be available until sometime next year.

a. Last Year's Accomplishments
As part of the VFC program, transaction data for 2009 indicates that Kentucky Immunization Program (KIP) distributed 654,492 vaccine doses to public providers and 389,526 vaccine doses to private providers, for a total of 1,044,018 doses, for administration to Kentucky children aged 0 to 18 years of age. Vaccines distributed by KIP cover Diphtheria, Tetanus, Haemophilus influenzae B, Hepatitis A, Hepatitis B, HPV, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rotavirus, Rubella and Varicella. Transaction data cannot be extrapolated by age.

The most current NIS data (July 2008 -- June 2009) indicates a coverage rate of 74.5% (CI 5.6) for the 4:3:1:3:3:1 immunization series of Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus influenzae B, Hepatitis B, and one or more doses of varicella for children 19 to 35 months of age. This is a slight drop in coverage rate for this series of vaccines compared to the previous data for 2008. Most likely this drop is a reflection of a shortage of Haemophilus influenzae type b vaccine due to manufacturing issues. NIS data also calculated coverage rates for states and territories during this same time period without including the coverage for Haemophilus influenzae type b (a 4:3:1:-:3:1 series). Kentucky's coverage rate for this series is 84.0% (CI 4.7). NIS data reflects a sample of children in Kentucky, regardless of their participation in the VFC program, and is a more accurate reflection of coverage than KIP could provide. However, NIS data reflects immunization practices from September 2006 to June 2009 and does not provide coverage data for all immunizations provided by KIP.

KIP developed and implemented the use of a new internally developed and CDC approved AFIX manual for use by the Immunization Field Staff as they conduct AFIX site visits. The AFIX workgroup met once per month in person and as needed in between meetings to develop the AFIX manual. The field staff who participated in the workgroup pilot tested the manual. In December 2009, all twelve field staff were trained in the use of the procedures in the manual.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Purchase of vaccines to cover the underinsured, non-Medicaid and non-KCHIP children			X	
2. Continued financial support for immunizations from the KIDS NOW Early Childhood Authority				X
3. Continued program activity by the Division of Epidemiology and Health Planning Immunization Program				X
4. Partnerships with the Department for Education and Head Start to include immunization as a requirement for enrollment				X
5. Increased outreach by local health departments for EPSDT / Well Child Preventive health visits				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
An additional $485,000 has been added to the State FY 08-09 budget and $1,750,419 has been added to the Kids Now Tobacco Settlement vaccine funding for vaccination of underinsured children. The cost of vaccines has risen approximately 14% from 2008 to 2009. The cost to vaccinate a child increases each year.

KIP is currently working on developing a secure and confidential web-based Immunization Registry through a contract with Custom Data Processing (CDP) that will ensure that all persons within the Commonwealth of Kentucky are protected against vaccine-preventable disease. The registry will be used to identify pockets of need, consolidate records for individuals who do not have a medical home or who move, minimize vaccine administration errors and help to measure the effectiveness immunization campaigns. The registry is projected to go online for pilot testing in mid 2010.

The KY Immunization Registry Workgroup, composed of representatives from LHDs, the Deputy Commissioner for DPH, Epidemiology and Health Planning Division staff and KIP staff, met during 2009 in preparation for pilot testing of the registry in 2010. Pilot testing is scheduled to begin in 2010 with anticipated expansion to occur in the months following pilot testing.

KIP field staff have begun using the AFIX manual developed in 2009, and have also begun pilot testing of an adolescent AFIX program to improve the immunization coverage level of adolescents who are patients of VFC providers across KY.

c. Plan for the Coming Year
In addition to annual VFC/AFIX activities and school surveys in 2011, KIP will finalize protocols for performing adolescent AFIX visits and implement these visits fully.

Furthermore, the Immunization Registry is expected to complete pilot testing during late 2010 and early 2011 and begin implementation statewide.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective	21	23	23	23	23
Annual Indicator	23.9	25.2	25.0	24.7	23.9
Numerator	1994	2141	2139	2098	2031
Denominator	83328	84817	85420	85072	85072
Data Source				KY live birth certificate files and U.S. Census Bu	KY live birth certificate files year 2009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	23	22	22	21	21

Notes - 2009
2009 data is preliminary and numbers could change. The 2009 Census population estimates are not currently available therefore the denominator reflects 2008 census population estimates.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
2007 data is preliminary and numbers could change.

a. Last Year's Accomplishments
PRAMS data suggests teens have the highest rate of unintended pregnancy. The KY PRAMS pilot indicated that younger women were indeed more likely to have unintended pregnancies: <20 (65.4%), 20-24 (41.5%), 25-29 (30.5%), 30-34 (30.8%) and >35 (50.0%). Those with a lower level of education were also more likely to have unintended pregnancies: < High School (48.0%), High School (47.8%) and > High School (32.6%). Unmarried women had an unintended pregnancy rate of 57.7% while married women's rate was less than half that, 25.5%. Medicaid recipients had a rate of 59.9%, uninsured individuals had a rate of 55.2% and those with private insurance had a rate of 26.6%.

Both teen pregnancy rates and teen birth rates are typically higher in the state of Kentucky than national rates. Since 1999, the Kentucky rate for teen pregnancy for teenagers 15 -- 17 years old has shown an overall downward trend from 34.9/1,000 to 29.4/1,000 in 2007. After a downward trend in preceding years, Kentucky's teen birth rate for teenagers 15 -- 19 years old, spiked in 2006, from 47/1,000 in 2005 to 54/1,000. According to preliminary data, the 2009 teen birth rate is 52/1,000. The most recent teen birth rate for the United States, in 2006, is lower than Kentucky at 42/1,000.. The teen pregnancy rate for 2008 and 2009 is not final at this time.

The Little Sandy District Health Department (LSDHD), Grayson Kentucky, has partnered with their local hospital to provide family planning services on high school campuses. King's Daughters Hospital is providing the mobile unit which is equipped to perform physical exams and provide privacy for counseling. LSDHD provides the clinical staff and supplies necessary to provide family planning services. The mobile LSDHD unit provides services one day a month at three high schools, two in Carter County and one in Elliott County, and average seeing 8-10

students each visit.

The Department for Public Health through the Division of Women's Health (DWH) and the Maternal Child Health Division (MCH) took an assessing look at teen pregnancy in Kentucky throughout FY 2009. The DWH assisted MCH in conducting eleven Public Forums throughout Kentucky in the Spring/Early Summer of 2009. MCH surveyed the clients in their local health departments/districts through the fall of 2009 regarding the health concerns that they have for themselves and their families. A Sexuality Education Survey was sent to 521 middle and high schools in the 170 public school districts in the Commonwealth of Kentucky in October, 2009. Teen Impact Groups, a focus group format, were conducted in nine high schools across the Commonwealth by the Adolescent Health Initiative Coordinator and staff of the DWH in early 2010. Participants were students age 16 and older. Impact groups were conducted in urban, rural, alternative, and suburban schools. knowledge was gained from the teen participants of these groups and it has greatly impacted the direction of the teen pregnancy prevention program in Kentucky. Significantly, the teens reported that the want sexuality education every year or every other year to reinforce what they know and they want their parents to be better equipped to communicate with them. Secondly, the teens reported that they want more to do with their time and that they want to be involved in their communities. The groups also stated that they want more 'one on one' time with adults and that they need adult mentors who care. They stated that barriers to teen pregnancy prevention programs include a lack of time, a lack of funding, and a lack of volunteers and transportation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued strategic planning with partners				X
2. Continued training opportunities through the Title X Family Planning funding support				X
3. Partnership coordination with the Coordinated School Health program to encourage schools in positive youth development				X
4. University of Kentucky Young Parents Program, Pike County Male Special Initiative Project and Teen Pregnancy Prevention Intervention Program	X	X		X
5. Partnership with the Kentucky Teen Pregnancy Coalition				X
6. Strategic Planning with partners from AMCHP, HIV, and STI Prevention and Adolescent Health				X
7.				
8.				
9.				
10.				

b. Current Activities

The Kentucky Family Planning Title X Program has several special initiatives targeted to service disparate populations. Two Hispanic clinics target low income under insured Hispanic clients. Brighton Center, Inc., a non-profit community based organization in Newport, Kentucky, offers the Youth Development Program in four (4) school systems in Campbell County. This program teaches adolescents and pre-teens positive youth development skills and refusal skills toward risk taking behaviors. Family Participation Workshops encourage parent participation in the decision of minors seeking family planning services. The Pike County Male Special Initiative Project services a local health department clinic, a college based clinic, and an in-school program for middle school males who are taught goal setting and self esteem skills. Title X also helps fund the University of Kentucky Young Parents Program (YPP) and the Center for Adolescent Pregnancy Prevention (CAPP) in Louisville. Both programs provide intensive counseling to teens to prevent pregnancies and repeat teen births and also provide comprehensive adolescent

preventative health care services.

A Kentucky Teen Pregnancy Prevention Team (KTPPT) was established in January, 2010 to use the data develope a state plan. The DWH conducted a Teen Pregnancy Prevention Summit on May 10, 2010. The 175 participants represented 68 of the 120 counties in Kentucky.

c. Plan for the Coming Year

The Adolescent Health Initiatives Coordinator has applied for both Tier 1 and Tier 2 Teen Pregnancy Prevention Grants. If awarded, Tier 1 funding will be used to implement the Teen Outreach Program (TOP™) through eleven local health departments/districts serving 21 counties in Appalachia Kentucky. Tier 2 funding will be used to implement the WISE GUYS(r) Program through 14 local health departments/districts in 38 counties across the State.
Abstinence Education Federal Title V 510B funding and a new funding stream-Personal Responsibility Education Program (PREP) were provided in the Health Reform Act. Both of these funding steams to the states for teen pregnancy prevention will be utilized in Kentucky under the specifications of the grant announcements that are slated to be released in late June and mid July.
Strategies for the KTPPT goals with resources and guidelines will be made available and disseminated in mid-late fall, 2010. Title X Goal: Assure access to comprehensive quality family planning services; provide comprehensive reproductive prevention services; to assist women, teens and men to prevent unintended teen pregnancy; teens will delay sexual involvement and the pregnancy rate for teens will be reduced; teens will report less risk taking behaviors as reported in the Youth Risk Behavior Survey

The TPPT, which is comprised of 27 members includes public health educators from different areas of the state; DPH staff from DWH, MCH, MHMR; physicians in Adolescent GYN and Pediatrics; Community Based Organizations (CBO) that address teen pregnancy; KDE staff; Youth Service Center (YSC) staff (each school in Kentucky has a Youth Service Center); a member of the Governor's Commission on Women; school nurses; and a teen mother, will meet a minimum of twice a year to evaluate the progress of the establish goals and to refine the activities and implementation plan as needed. TPPT plans to publish a TPP Strategic plan resulting from the Teen Pregnancy Prevention Summit defining these established goals, objectives and implementation guidelines are in process and should be completed by Fall, 2010. This publication will be disseminated to stakeholders across Kentucky.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	33	33	30	31	31
Annual Indicator	29.0	29.0	29.0	23.9	23.9
Numerator	15222	15222	15222	18790	18790
Denominator	52489	52489	52489	78505	78505
Data Source				U.K. denatl sealant program data	UK dental sealant program data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	26	26	26

Notes - 2009
The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

2009 data is currently not available data for this indicator actually reflects year 2008.

Notes - 2008
The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
The survey was last conducted in 2004. The Oral Health program anticpates conducting the survey next calendar year and will have updated data the following year.

a. Last Year's Accomplishments
The dental sealant program for school-aged children also began in July 2003. Last year, the Kentucky Sealant Program funded 15 health departments at a total of $180,000 through general state funds. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to contract with dental professionals to place sealants in children that had need to do so. Most programs focused on sealant services in second, third and, rarely, six graders throughout the Commonwealth. Parents were informed on the program through informed consent signature forms. In CY09, approximately 11,000 sealants were provided to children through this program.

2009 Accomplishments include the following: The KOHP continues to fund school-based sealant programs through 15 health departments. The health departments reported approximately 6500 sealants were applied to children thorough the program. From July 1, 2009-January 31, 2010, approximately 3100 sealants had been applied to children through the program. The final data for 2010 will be unavailable until the close of the state fiscal year on June 30, 2010. There has been no consistent process for reporting sealant application through the program.

The KOHP developed and designed a dental sealant reporting system with CDP, the IT vendor for most local health departments. All the local health departments will be trained on the the sealant reporting system. This new system will provide more accurate data collection since all health departments will be using the same system. The reporting system was modeled after the CDC SEALS software with changes relevant to the state reporting requirements and system. In this system, KOHP will be able to link children to providers and get detailed demographic information on these children. This system will also help the KOHP to identify children in need of restorative care. Reporting of referrals made to the local dentist is incorporated in the software and thus follow up on these children can be monitored.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Provides grant to selected local health departments to fund local level dental provider partnerships for sealants.		X		
2. Ongoing support of the Kentucky Children's Oral Health Surveillance System, tracking oral disease and sealant use throughout the Commonwealth.				X
3. Continued oral health education at the local level to families, health providers, including nurses and physicians, and the community			X	
4. KIDS Smile Fluoride Varnish Program through local health departments, which includes the application of fluoride varnish and good oral health care education to the parents and family.	X		X	
5. Continued partnership with the University of Kentucky College of Dentistry and their sealant outreach program, reaching children statewide and especially in rural, underserved areas				X
6. Ongoing strategic planning for children's oral health care in Kentucky				X
7. Continued collaboration with the UK Center for Rural Health with their growing outreach to underserved populations in rural Kentucky				X
8.				
9.				
10.				

b. Current Activities

During CY09 and FY10, the Kentucky Oral Health Program continues to fund sealant activities in 15 health departments. The allocations range from $4,000 to $24,000, depending on the number of services performed per participating health department. Local health departments and their community partners continue to move the identified child to the contracted dental office for sealant services.

The Oral Health Program is currently working with the DPH Administrative and Financial Management Division as well as Custom Data Processing in researching, developing and implementing a uniform sealant activity reporting program. Among the goals of this software-based program are to capture appropriate services for this funding stream. This should be finalized in the late summer of 2010, with testing then implementation by October 2010.

The Kentucky Oral Health Program (KOHP) is in its third year of the four-year Targeted MCH Oral Health Service Systems (TOHSS) Grant and received funding of $160,000/year to advance the state oral health program toward sustainability and provide a statewide approach to preventing oral disease by expanding preventive and restorative oral health services for Medicaid and State Children's Health Insurance Programs (SCHIP) eligible children and other underserved children and their families.

The Kentucky Oral Health Program continued its relationship with the University Of Kentucky College Of Dentistry to Kentucky's underserved pediatric population.

c. Plan for the Coming Year

The Kentucky Oral Health program is planning to reevaluate their sealant program including its structure, its funding, it reporting and its effectiveness. The sealant program, ideally, would be school based in its service sites. The challenge comes in Kentucky with the shortage of dentists, layered with the shortage of dentists that are willing to provide preventive services in the school based setting. Recent changes in the dental practice law, allowing public health dental hygenists to see children, will catalyze the development of a sealant program that will be school-based

more than contract-dentist based, which is a recognized 'Best Practice' by the Association of State and Territorial Dental Directors. It will use the limited funding through the most effective sealant delivery system in public health: its school-based services.

The Kentucky Oral Health Program will continue its long standing contractual relationship with the University Of Kentucky College Of Dentistry to underwrite their efforts in outreach services to Kentucky's underserved pediatric population. The fund allows the University to expand its services geographically in the upcoming year. While continuing their fixed clinic and mobile dental outreach in southeastern Kentucky as well as their mobile outreach and fixed clinic in Madisonville, they are implementing a significant expansion of their program in the northeastern part of the state. Their mobile dental services for children throughout the state will continue in areas they identify as underserved with emphasis on prevention (including sealants).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	4.6	4.5	3	2.5
Annual Indicator	5.0	4.6	2.5	2.9	2.8
Numerator	41	38	21	24	23
Denominator	823524	828830	828157	833890	833890
Data Source				KY vital stats death certificate files & U.S. cens	KY vital stats death cert files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.5	2	2	2	2

Notes - 2009
2009 data is preliminary and numbers could change. 2009 census population estimates are not currently available therefore, 2008 population estimates were used for the denominator.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
2007 data is preliminary and numbers could change.
Because 2007 data is preliminary, future objectives for National Performance Measure #10 will not be revised at this time.

a. Last Year's Accomplishments

In 2008-9, KY State Safe Kids sponsored (and paid for with Safe Kids Buckle Up funds) a 4-day CPS certifying class for Kentucky State Police (KSP) troopers, which included at least one trooper from every post in Kentucky. Special emphasis was also given to ensuring that KSP were familiar with the new booster bill and could assist in local education/implementation. Two additional 4-day national CPS certifying classes in geographically dispersed areas were given that year. In 2009-10, two 4-day CPS trainings were conducted, along with 2 recertification classes for previously-certified CPS techs and one update class to upgrade the knowledge and skills of rural CPS techs.

Implementation efforts of Booster bill- In 2008-9, the newly passed state booster bill generated warnings only, with ticketed enforcement starting in July 2009. Safe Kids and KIPRIC staff have successfully written two Safe Kids legislative enforcement grants in partnership with other Safe Kids Coalitions across Kentucky, for a total of several thousand dollars. This funding was utilized in 2008-9 to purchase a training DVD on booster seats and booster law for every single law enforcement agency across the state of KY.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with other CDC grants including the Core Injury Prevention grant and the Kentucky Violent Death Reporting Systems grant, both administered by DPH and include multiple partners and collaborations.				X
2. Enhancement of the Child Fatality Review process to increase the development and participation of local CFR teams				X
3. Injury prevention training included in the HANDS Home Visitation curriculum				X
4. Collaboration with the Kentucky Injury Prevention Research Center at the University of Kentucky				
5. Participate in the Governor's Drive Smart Team that includes safety seat checkups and other safe driving initiatives				X
6. Collaboration with Coordinated School Health to provide safety information brochures				X
7. Continuation of the Kentucky Safe Kids Coalition adn local Safe Kids chapters				X
8. Publication of the Child Fatality Review annual report				X
9. Ongoing strategic planning for children's safety and injury prevention in Kentucky				X
10. Passage of the Booster Bill into law July 2008 enforcing proper restraint of children in motor vehicles and punishable as a crime with a monetary fine				X

b. Current Activities

National fact sheets in English and Spanish on need for boosters and proper use have been widely distributed to local and regional health departments, child care agencies, elementary school family resource centers, children with special health care needs, and foster care workers and families. Booster seat information is a major part of every Fire Safety Day with hundreds of people reached every year.

Child care booster seat project- MCH and the MCH/KIPRC pediatric injury staff were asked to work with Child Care on a Federal Stimulus Funds project to distribute booster seats to child care centers that transport low income children. During 2009-10, phone calls were made to 686

centers to gather information on the types of vehicles utilized for child transport. After eligible centers and types of booster seats needed for major vehicles in use were determined, regional trainers were identified and initial orders of booster seats submitted.

c. Plan for the Coming Year
In 2010-11, eligible child care centers will bring their vans to a local or regional training and will receive their seats after 2-hours of training with child care credit on booster seats in general and how to best install theirs in their specific vehicle.

Follow-up is being done with local law enforcement agency data across the state to assess number of citations written, and to provide recognition incentives to police departments that do improve pediatric motor vehicle safety through booster seat citations.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	26	28	29
Annual Indicator	25.3	27.5	23.2	28.9	28.9
Numerator	13915	3980	3416		
Denominator	55000	14465	14725		
Data Source				CDC National Immunization survey state specific da	CDC National Immunization survey state specific da
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29	30	30	31	31

Notes - 2009
2009 data is not currently available data shown reflects year 2008.

Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.

The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2008
Numerator and denominator information are not available for this indicator as the data source is now the CDC National Immunization Survey.

The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
Data reflects 2006 data. The 2007 data is not yet available.

a. Last Year's Accomplishments
During 2009, breastfeeding initiation and duration rates were increased through training, education, promotion and support. Seven (7) breastfeeding coalitions including a statewide coalition met and provided continuing education, support and leadership for health professionals. World Breastfeeding Week was held in August and included activities across the state for mothers and health professionals, as well as press releases. The Rock and Relax Room was continued at the State Fair. Funding was continued for the ten Breastfeeding Regional Coordinators. Training and technical assistance was provided to the Peer Counselor sites and the total number of sites continued at 13. Education materials continue to be developed and translated into Spanish. The breastfeeding bill, KRS 211.755 continues to be promoted in an effort to increase awareness about breastfeeding protection in public places. KRS 29A.100 allows breastfeeding mothers to be excused from jury duty. Collaboration continues with Obesity team and Partnership for a FIT Kentucky, who include breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping Kentucky's Future Policies to Reduce Obesity. Collaboration continues with the University of Kentucky and other public and private partners. The Baby Friendly Hospital Initiative continues to be promoted. Staff continues to work on new ideas to promote breastfeeding in Kentucky. There is ongoing collaboration with the Partnership for a FIT Kentucky, University of Kentucky and other public and private partners as staff continue to promote, support and provide education about the breastfeeding. Collaboration continues with Obesity team and Partnership for a FIT Kentucky, who include breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping Kentucky's Future Policies to Reduce Obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Training and support of WIC Breastfeeding grantees for breastfeeding promotion in local communities				X
2. Continued Breastfeeding Coalition building				X
3. Training provided to local hospitals and community supporters / partners				X
4. Promotion and training of the health benefits of breastfeeding in the HANDS Home Visitation curriculum				X
5. Promoted the breastfeeding bill, Senate Bill 106 in an effort to increase awareness about breastfeeding protection in public places				X
6. Continued collaboration with Fit KY, Regional Breastfeeding Coordinators and Shape the Future Steering Committee				X
7. Collaboration with CDC Nutrition, Physical Activity and				X

Obesity Grant				
8. Worked with USDA to host the NWA Breastfeeding and Nutrition Conference held in Kentucky in September 2008				X
9.				
10.				

b. Current Activities

Promotion and support of increased breastfeeding initiation and duration rates through continued education are continuing. Efforts continue to increase participation and formalize the state breastfeeding coalition. A Breastfeeding Summit was held in April and was attended by public and private partners. Funding continues for the 10 Breastfeeding Regional Coordinators. Section staff and Regional Breastfeeding Coordinators are working to increase the number of hospitals trained on breastfeeding promotion and support. WIC participants receive hospital grade and single user breast pumps to support duration. The Baby Friendly Hospital Initiative is being supported across the state. New education modules are being made available to local agency staff on breastfeeding promotion, breastfeeding education and three-step counseling. Kentucky received a HRSA grant for Business Case for Breastfeeding and conducted training the toolkit is being implemented in collaboration with Partnership for a FIT Kentucky and the Kentucky Chamber of Commerce. Collaboration continues with Obesity team and Partnership for a FIT Kentucky, who include breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping Kentucky's Future Policies to Reduce Obesity. The Breastfeeding Peer Counselor Program is continuing in 13 sites and increasing to 3 more. A state-wide breastfeeding coalition has been developed.

c. Plan for the Coming Year

Staff will distribute a Breastfeeding Needs Assessment and analyze information. Efforts will continue to work to increase breastfeeding initiation and duration rates through continued education, promotion and support. Efforts will continue to increase participation in the statewide breastfeeding coalition. The World Breastfeeding Week will be celebrated in Kentucky during August. Funding will be maintained and continued for the 10 Breastfeeding Regional Coordinators. Intensive breastfeeding training will be offered in the state to increase the number of IBCLC's. Staff will continue to provide breastfeeding and nutrition continuing education programs. Efforts will be focused on increasing the number of hospitals trained on breastfeeding promotion and support. Breast pumps (hospital grade and single user) will continue to be provided to WIC mothers. The Baby Friendly Hospital Initiative will continue to be supported and promoted in the state. Online education modules on breastfeeding and nutrition will continue to be developed for local health department staff training. The Breastfeeding Worksite Toolkit will continue be promoted throughout the state along with Health Care Reform. Collaboration continues with Obesity team and Partnership for a FIT Kentucky, who include breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping Kentucky's Future Policies to Reduce Obesity. The staff will continue to promote and support breastfeeding and nutrition through participation in health fairs and conferences with displays and education materials. The Breastfeeding Peer Counselor Program will be continued in 16 sites and will be increased to other sites with additional funding. Collaboration will continue with the Partnership for a FIT Kentucky, University of Kentucky and other public and private partners. Efforts will continue to focus on breastfeeding legislation. Staff will continue to revise and develop breastfeeding and nutrition education materials for local agencies. Participation in health fairs and the Rock and Relax room at the State Fair continue with an effort to promote and support breastfeeding and nutrition. The Breastfeeding Peer computer system will be revised and updated. A State Plan will be developed as the result of Breastfeeding Summit. Kentucky will participate in World Breastfeeding Week during August 2010.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99
Annual Indicator	99.8	99.8	99.0	97.8	99.9
Numerator	51837	51837	57619	55635	55250
Denominator	51932	51932	58184	56886	55290
Data Source				EHDI Program (CY 08)	As of 5/20/10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
The data for this PM is provided by the KY Early Hearing Detection and Intervention program.

a. Last Year's Accomplishments
In March 2009, HB 5 implementing a voluntary compliance system (requiring participating audiologists to report hearing evaluation information on the population age birth to 3 years) passed and was signed into law by Governor Beshear. Following passage of that statute, promulgation of regulations establishing Approved Infant Audiology Diagnostic Centers began. Additionally, through CDC grant funding the KY-CHILD expansion included an application for audiologists outside the CCSHCN to enter audiology results electronically and that pilot program was completed in November 2009 with full implementation in early 2010 following on site training of all audiologists in the Approved Infant Audiology Diagnostic Centers. The EHDI program continues to tackle the National 1-3-6 goals (screening by 1 month of age; diagnosis by 3 months; intervention by 6 months), recognizing as our focus shifts to the follow up goals that we must continue to be vigilant to assure that our screening percentage does not diminish.

With the network of audiologists working directly with Kentucky's birthing hospitals, the EHDI core staff can concentrate on supporting audiologists throughout the state as they adjust to the requirements of the mandate, and can work to assure that families and children access the resources for diagnosis and intervention.

Data indicates that the percentage of infants screened prior to discharge from the hospital to be 97.8% in 2008 and 99% in 2009. The focus in Kentucky has shifted to accomplishing the national goals of permanent childhood hearing loss (PCHL) diagnosis before 3 months of age and intervention before 6 months of age. The electronic submission of hearing screening reports which began in October of 2006 through the KY-CHILD program has eliminated some errors found with paper submission of hospital screening.

In 2009, the EHDI program merged with CCSHCN's Audiology Branch, after a period of preparation and training for the staff audiologists so they could support the hospital Universal Newborn Hearing Screening programs in their areas. As a part of this smaller community approach, the audiologists meeting with UNHS hospital staff will begin to assess the need for

equipment upgrades. Additionally, the KY-CHILD expansion for audiology follow up has rapidly advanced with training of the trainers in August. CCSHCN audiologists and EHDI staff have been trained to support audiologists in other settings throughout the Commonwealth of Kentucky. EHDI team presented a poster on pediatrician responses to a survey regarding their experience with children with hearing loss and their views on the follow up of infants who referred on newborn screening. Regulations for the new mandate, HB 5, were promulgated and then approved December 16, 2009 with full implementation January 1, 2010.

As a part of the State Plan developed at the EHDI National Conference, CCSHCN EHDI began to work with the Commission for Deaf and Hard of Hearing and with Kentucky's Hands and Voices (family) organization to facilitate some of their goals including "Guide by Your Side". Supplemental grant funding provided means to support these two organizations so that a facilitator for Hands and Voices could be hired to organize families, fundraising and move forward with Guide by Your Side training.

As a method for establishing and maintaining the highest standards for the CCSHCN Audiology-EHDI program, a tool was developed for assessing performance of our own audiologists based on the Best Practices model recommended by the American Speech-Language Hearing Association (ASHA). This model of continuous quality monitoring involves self assessment, peer audit and administrator audit on an intentional timeline. This tool was piloted in October, refined and then rolled out for CCSHCN audiologists across the state. By assessing ourselves and holding ourselves' to the highest standards we can then move forward with supporting the whole EHDI process from hospital through diagnosis with the earliest possible intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The EHDI program provides on site support to all KY birthing hospitals.	X			
2. KY birthing hospitals screen all newborn hearing prior to hospital discharge.	X		X	
3. Results from hospital screenings are submitted electronically to the EHDI program. Information is maintained in the CCSHCN electronic data system.				X
4. Information is mailed to families of children who have a newborn hearing screen report indicating a risk for hearing loss. The information provides information about the risk and diagnostic audiological follow-up resources.		X	X	
5. The EHDI program provides follow-up to families who are not documented as having received diagnostic audioligcal testing.	X	X	X	X
6. The EHDI program employs a coordinator to provide oversight to the loss to follow-up initiative.	X	X	X	X
7. The EHDI program manages two grants from HRSA/MCHB and the CDC to be used in reducing the loss to follow-up rate.			X	X
8. The EHDI program partners with the Office of Technology to coordinate an electronic system of information with hospitals and audiologists.			X	X
9. The EHDI program provides outreach and training to stakeholders.			X	X
10. Information about the EHDI program is available on the CCSHCN website (in English and Spanish).	X		X	X

b. Current Activities

CCSHCN will implement KY-CHILD electronic reporting and "Approved Audiology Centers" list. Expectation that more infants identified with hearing loss prior to 3 months of age will be entered into the CCSHCN data system and the need to provide intervention resources to families. Collaboration will continue with Kentucky Commission for Deaf and Hard of Hearing (KCDHH) who provide information and resources to send to affected families.CCSHCN Staff will have presentations at Kentucky Speech Language and Hearing Association and at EHDI National Conference.

Memorandum of Agreement with First Steps (IDEA Part C) to provide audiology diagnostic services and sharing of data. Expansion of UNHS hospitals participating in grant so that referral from screening to evaluation to reporting of data is refined in all areas. Replacement of non-supported audiology diagnostic equipment in CCSHCN offices so that services to infants and children are not compromised by lack of availability and access due to equipment. Completion of training for electronic reporting so audiologists in Approved Infant Audiology Diagnostic Centers are trained to enter hearing test results into the KY-CHILD system. As of May, 2010 over 200 audiology reports had been entered into system. Applications need to be ready to transfer from KY-CHILD to CCSHCN CUP and are in process; initial data transfer is ready to begin. Implementation of Cochlear Implant Program to provide team approach to support families and children

c. Plan for the Coming Year
Expansion plan of KY-CHILD applications to include electronic entry or transfer of early intervention evaluations, enrollment and other outcomes. Reduction of loss to follow up at diagnosis and early intervention that occurs due to loss of documentation due to the access of electronic reporting. Increase the number of enrolled Approved Infant Diagnostic Audiology Centers. Continued technical assistance to hospital UNHS programs.
Quality monitors that assess best standards, family services, and set goals for improvement. Continuation of collaboration with First Steps, KCDHH, and Hands and Voices to improve outcomes for children identified with hearing loss and to work with families to find resources to overcome barriers. Increased involvement with Public Health Departments and midwives in the screening and re-screening of newborns.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	7.5	8.5	9	8
Annual Indicator	6.7	9.7	8	10	10
Numerator					
Denominator					
Data Source				U.S. Census Bureau Current Population Survey for 2	U.S. Census Bureau Current population survey for 2
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9	9	8	8	7

Notes - 2009
2009 data not available yet, so 2008 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2008
Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2007
2007 data not available yet, so 2006 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

a. Last Year's Accomplishments
Like states throughout the nation, Kentucky endured an economic challenge in calendar year 2009 including loss of sources of employment with increases in the numbers of families living below the federal poverty level. While Kentucky's economy continued to decline last year, Governor Beshear's statewide KCHIP enrollment plan was implemented throughout the state by a broad range of state and community partners working together to increase enrollment of Kentucky's children in KCHIP by more than 35,000 children by June 30, 2010. These partners included but were not limited to the Department for Medicaid Services, the Department for Public Health, the Department for Community Based Services, Family Resource and Youth Services Centers, Kentucky public schools, community providers, the United Way, Kentucky Youth Advocates, Foundation for a Healthy Kentucky, Kentucky Action for Healthy Kids, and in 16 Kentucky counties, Passport Health Plan. The following Department for Medicaid Services administrative changes were implemented and decreased barriers that have kept families from enrolling their children in the Kentucky Children's Health Insurance Program (KCHIP): eliminating the face to face interview, simplifying the KCHIP application, distributing KCHIP Mail In applications, extending the grace period for replying to requests for more information to complete applications, training statewide community providers and agencies to assist families with enrollment processes, hiring more personnel to process applications and increase outreach. In FY 09, the DMS and the DPH sponsored Train the Trainer conferences including live and on demand webcasts and on site trainings to encourage participation of statewide agencies and providers in identifying and enrolling eligible children in KCHIP. Additional funds were allocated to one independent health department to conduct statewide community outreach and Train the Trainer activities beginning in April 2009 and continuing throughout CY 09.

The Department for Public Health contracted with statewide health departments to contact families of eligible children by phone, in clinic or during home visits, and provide assistance with completing KCHIP applications through activities of Health Access Nurturing Development Services and the EPSDT and KCHIP Outreach programs. Families who choose not to complete an application at the time of visit or decline assistance on the phone were provided or mailed an application and encouraged to contact local health department, local Department for Community Based Services offices or, in counties with Passport Managed Care, Passport representatives to make appointments or obtain assistance to complete KCHIP applications. Families who contacted the DPH administered hotline were assisted with completing the KCHIP application or are provided an application and encouraged to contact local health department, Department for Community Based Services, or in counties with Passport Managed Care, Passport representatives for assistance with completing KCHIP applications. KCHIP hotline health department staff worked with the Department for Medicaid Services to follow up with families

about KCHIP enrollment status. As a result of local health department efforts, as many as 7,232 families were provided KCHIP applications and offered or provided assistance with completing, submitting and tracking the status of the applications. A total of 363,000 families of eligible or uninsured or underinsured children obtained information about KCHIP and EPSDT through community schools, providers and agencies and 10,130 individuals and agencies obtained information about KCHIP or assistance with KCHIP enrollment as a result of contacting the DPH KCHIP hotline.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued support for Medicaid / KCHIP enrollment and services through local health departments and the Commission for Children with Special Health Care Needs				X
2. Collaboration with Medicaid to access needed data for MCH programs				X
3. Collaboration with Medicaid / KCHIP program initiatives				X
4. Collaboration with EPSDT Outreach through local health departments				X
5. Collaboration with Local Health Department Well Child programs				X
6. Continue availability and processing of Mail-In applications to increase enrollment in KCHIP program				X
7.				
8.				
9.				
10.				

b. Current Activities

Statewide efforts to implement the Governor's KCHIP enrollment plan have exceeded the goal to enroll more than 35,000 children by June 2010. As of April 2010, an additional 41,795 children were enrolled in Medicaid and KCHIP since the beginning of the initiative on November 1, 2008, equivalent to 65.27% of the total number of children estimated to be eligible for KCHIP. Community providers, schools and agencies can now review KCHIP application training available on the Kentucky Department for Medicaid Services website. Local health departments provided KCHIP applications and offered or provided assistance with completing, submitting and tracking the status of the applications efforts to as many as 11,576 families of uninsured or underinsured children in Kentucky. As many as 379,378 families of eligible or uninsured or underinsured children will be provided with information about KCHIP and EPSDT through community schools, providers and agencies and as many as 11,279 individuals and agencies will be provided information about KCHIP or assistance with KCHIP enrollment as a result of contacting the DPH KCHIP hotline.

c. Plan for the Coming Year

During CYs 2011, the Department for Public Health will work with computer services partners and resources to enhance the following EPSDT Outreach activities with follow-up to include KCHIP eligible children: identifying children in need of preventive health services and coverage through outreach in local health department clinics and partnering with statewide and community providers and agencies to make families of eligible children aware of the need for preventive health services. DMS and DPH will work with local health department outreach programs to engage providers in outreach and promote EPSDT services to families of children who are uninsured, underinsured or eligible for KCHIP. The Department for Public Health will pursue

further improvement of EPSDT Outreach in state fiscal year 2011 by evaluating budget and planning goals and objectives including KCHIP Outreach activities, monitoring statewide and county outreach activity and expenditures goals and objectives quarterly and as needed, providing local health departments with training and technical assistance as well feedback about program performance, and collaborating with the Department for Medicaid services and health departments in 120 counties to increase public and provider awareness of EPSDT services.

Under contracts with the Department for Public Health, statewide health departments will continue to contact families of eligible children by phone, in clinic or during home visits, and provide assistance with completing KCHIP applications through activities of Health Access Nurturing Development Services and the EPSDT and KCHIP Outreach programs. Families who are contacted, respond to calls or contact the KCHIP hotline are provided or mailed an application, offered help with completing the application, encouraged to contact local health department, local Department for Community Based Services offices or, in counties with Passport Health Plan, PHP representatives to make appointments or obtain assistance to complete KCHIP applications. Under DPH contracts with local health departments, KCHIP hotline health department staff members will provide families with current information about enrollment status and follow up. Louisville Jefferson Department for Public Health and Wellness will work with Passport Health Plan representatives to help families of eligible children complete KCHIP applications and follow up on enrollment. Applications will be mailed or faxed to the central processing center, the Department for Medicaid Services or delivered to local Community Based Services offices, and tracked to assure applications are complete and to update enrollment status.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32	34	16	31
Annual Indicator	35.3	17.9	32.0	32.3	31.3
Numerator	45948	9626	18277	20294	21450
Denominator	130165	53777	57117	62832	68450
Data Source				Pediatric Nutrition Surveillance Survey for KY	Pediatric Nutrition Surveillance Reporting System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance	30	30	29	29	29

Objective					

Notes - 2009
For data year 2006, children between 2 and 5 who were obese were not included in the numerator only those at risk for being overweight were reported; therefore, the 2006 indicator appears lower than other years. For years 2007 and forward those children receiving WIC between the ages 2 and 5 at risk of overweight or obese were reported in the numerator.

Notes - 2008
For data year 2006, children between 2 and 5 who were obese were not included in the numerator only those at risk for being overweight were reported; therefore, the 2006 indicator appears lower than other years. For years 2007 and forward those children receiving WIC between the ages 2 and 5 at risk of overweight or obese were reported in the numerator.

Notes - 2007
Data is from the PedNESS survey.

a. Last Year's Accomplishments
During 2009, funding was provided for a network of Registered Dietitians/Certified Nutritionists to provide Medical Nutrition Therapy in 110 of 120 counties. Funding was also provided for community and school nutrition activities in all 56 agencies. The staff provided wellness and nutrition activities for employees in the Cabinet and at various health fairs. State and local staff provided nutrition information at the Kentucky State Fair and answered questions for attendees. Nutrition materials were developed or revised for local health departments to use with clients. The staff completed the nutrition monitoring for quality assurance in 20% of agencies. VENA training was provided to local agencies and implemented statewide. The new WIC Food Packages were implemented in May which resulted in fresh fruits and vegetables, whole grain breads and low fat milk being provided. Staff is a liaison to the following committees/coalitions: Kentucky Action for Healthy Kids, Partnership for a Fit Kentucky, Kentucky Diabetes Network, Folic Acid/Prematurity Partnership, School Health Coalition, AHEC Health Careers Outreach and Kentucky Food Security Partnership.
Kentucky's WIC Program is available in all 120 counties. The WIC Program provides counseling to all children and women concerning healthy foods and the importance of regular physical activity. The caseload for WIC is approximately 145,979 participants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Physical Activities promoted through local health departments		X	X	X
2. Nutritional counseling to families available through local health departments		X	X	X
3. Collaboration between local health departments and schools to promote physical activity and nutrition			X	X
4. Wellness and nutrition activities provided for Kentucky employees and nutrition information provided at the Kentucky State Fair		X	X	
5. HANDS Home Visitation services		X	X	
6. Provided leadership and education for participation in WIC Farmer's Market Nutrition Program				X
7. Well Child and Adolescent Preventive Health and Nutrition servcies training for local health department staff				X
8. Continued collaboration and strategic planning with multiple partners				X

9. Automated BMI and Growth Charts				X
10. Expanded WIC Program in all 120 counties, statewide, that provides counseling to all children and women on healthy foods and the importance of regular physical activity.				

b. Current Activities

The new WIC Food Packages which provide fresh fruits/vegetables and whole grains with a reduction in juice continue to be a success. Efforts continue to refine automated risk and growth charts. Funding continues for the local health department dietitian/nutritionist network. Nutrition and breastfeeding materials are being revised and updated and will be displayed at the State Fair. Quality assurance monitoring and technical assistance continues. Liaison relationships continue with Partnership for a Fit KY, Folic Acid and Prematurity Partnership, Arthritis Partnership, KY Diabetes Network, Breastfeeding Coalitions, Coordinated School Health Coalition, AHEC and the KY Food Security Partnership. Nutrition is a focus in employee wellness and employee health fairs. Work continues with KCTCS on the online education modules which will be pilot tested for use to train local health department staff. Training and technical assistance for local agencies will continue to be a focus. The Section staff will continue to act as a preceptor site for nutrition interns. A Breastfeeding Newsletter and Nutrition Newsletter are developed and disseminated on a quarterly basis. Nutrition and nutrition materials are developed and revised, as needed.

c. Plan for the Coming Year

For the future, the staff will continue to work on the web-based system for WIC and add a nutrition education module. The WIC Farmers' Market Nutrition Program will be continued if USDA funding is continued and staff will provide training, technical assistance and monitoring. The quality assurance monitoring will continue to be provided by staff and training and technical assistance will occur as needed. Funding will continue for the dietitian/nutritionist network to provide Medical Nutrition Therapy as appropriate. Staff will continue to offer nutrition leadership and provide opportunities as nutrition preceptors. Breastfeeding and nutrition materials will be developed or revised as needed. New materials will be developed for Medical Nutrition Therapy. Staff will continue to emphasize and develop a fruit and vegetable promotion program. The following programs will continue to have liaisons from the Section: Partnership for a Fit Kentucky, Folic Acid and Prematurity Partnership, Arthritis Partnership, KY Diabetes Network, Breastfeeding Coalitions, Coordinated School Health Coalition, AHEC, March of Dimes and the KY Food Security Partnership. The staff will continue to provide a nutrition focus in the employee wellness program and health fairs. A Breastfeeding Newsletter and Nutrition Newsletter will be continued on a quarterly basis. Nutrition information and displays will continue to be provided at the State Fair as funding permits.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		22	22	21	20
Annual Indicator	23.4	24.0	22.5	22.8	21.5
Numerator	12285	13092	13084	12891	11792
Denominator	52545	54614	58164	56596	54845
Data Source				KY Vital Statistics files, live birth certificate	KY Vital Statistics files live birth cert files

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	19	19	18	18

Notes - 2009
2009 data is preliminary and numbers could change.

The annual indicator increased and the annual performance objective was set at an decrease and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2008
2008 data is preliminary and numbers could change.

The annual indicator increased and the annual performance objective was set at an decrease and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2007
2007 data is preliminary and numbers could change.

a. Last Year's Accomplishments
KY still has one of the highest rates of smoking in the nation. Many years of efforts by the DPH Tobacco Control program are beginning to pay off. Smoking in women of childbearing age in KY is slightly decreased, but still at 32%. Middle school smoking is down, but high schoolers who smoke slightly increased on the last YRBS to 26%. Since 90% of smokers start as teen, DPH partnered with the KY AAP chapter to enhance office-based approachees to smoking cesstion. The DPH Tobacco Control program hosts regional youth advocacy training for the last five years culminating in a web page for youth groups to connect across the state. Youth can post their activities and photos on the site. The movement name is H.O.T. (Helping Overcome Tobacco).

Nearly one in four KY pregnant mothers smoke. In 2008 KY began the GIFTS (Giving Infants and Families Tobacco Free Starts) Program is a smoking cessation program, for pregnant women in the local health departments of 9 rural counties of eastern Kentucky where smoking rates are highest. The program was successful in achieving high quit rates (20%) despite the heavy use. The ultimate goal is to see a reduction in low birth weight and preterm births as well as perinatal deaths in the targeted area, but do to the lag in vital statistics data, that data is still being analyzed. More information about this program is identified in the attached Kentucky GIFTS presentation and can also be located at www.mcuky.edu/KYgifts GIFTS is now being rolled out to additional sites.

Local health departments assess every pregnant woman who presents to the local health department for about their use of alcohol, tobacco, secondhand smoke exposure, and other drug use at each health department visit and provide education and referrals. Diabetes & Tobacco Collaboration to increase cessation counseling and quit line referrals by diabetes educators. Quit linen callers are asked who referred them and if they have ever been diagnosed with diabetes (question is identical to BRFSS question). Baseline data will be collected prior to training

diabetes educators.

Local health departments continue to offer smoking cessation programs/classes, that are available to anyone referred from doctor's offices or other community agencies. The Tobacco Prevention and Control Program provides a state quit line (800 QUIT NOW) to all Kentucky residents free of charge. Beginning in November 2009, a 2-week supply of nicotine replacement therapy was offered to callers who were unemployed and enrolled in counseling.

The DPH provided a free annual Prenatal and Postpartum Training for LHD staff. Courses will be provided to raise awareness and educate staff on the effects of smoking and secondhand smoke exposure during pregnancy.

Healthy Communities, a CDC grant that addresses tobacco use as well as physical activity and nutrition, is managed by the Chronic Disease program. Grants were awarded to three cities/counties to develop and implement policies and programs in one or more of the three focus areas. Training and technical assistance was provided to the selected cities/counties as well other interested cities/counties.

24/7 Tobacco-free Schools. Coordinated School Health, the Tobacco Program, Kentucky ACTION, the Tobacco Program, and Northern Kentucky Independent Health District tobacco program are jointly planning a 24/7 Tobacco-Free Schools initiative. The group held their first meeting April 15 with school officials to encourage implementation. Presentations on 24/7 Tobacco-Free Schools were given at the Kentucky Public Health Association Annual Conference and Healthy Communities Conference.

Kentucky joined the National Alliance for Tobacco Cessation to participate in the EX Campaign which includes media (television, radio, posters, wallet cards, etc.) and a web page to help smokers quit and drive calls to 1-800-QUIT NOW. The quit line is a national portal that directs calls individual states' quit lines. The campaign began October 2009. Kentucky joined 17 other states in the Alliance. The QUIT line does have protocols to counsel pregnant women; however, in our GIFTS project, the women did not utilize the QUIT line and preferred counseling from a person they could meet and know.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuation of GIFTS Program targeting pregnant smokers with a goal to see a reduction in low birth weight and preterm births as well as perinatal deaths in the 9-county targeted area		X		
2. Tobacco Control Coordinators located in local health departments and patients screened at each visit about tobacco use and second-hand smoke exposure			X	
3. Kentucky's Tobacco Quit line, 1-800-QUIT NOW; 30 Quit Line billboards posted across Kentucky			X	X
4. Quit Line promotional toolkit provided to local health departments, hospitals, businesses, Kentucky Cancer Program (UK and U of L), Cancer Information Service				X
5. Quit Line PSA's developed and distributed to local health departments				X
6. Local health departments offer Cooper Clayton Method to Stop Smoking 12 week cessation program at no cost to participants.		X	X	

7. Regional youth advocacy training conducted over last 5 years has resulted in a web page for youth groups to connect across the state. This movement is named H.O.T. (Helping Overcome Tobacco)				X
8. Partnership with KMA to assist physicians in counseling patients to quit smoking				X
9. Training for local health department staff in Make Yours A Fresh Start Family and health departments providing Make Yours A Fresh Start Family counseling and services				X
10. DPH conducted a PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study soliciting responses to questions regarding smoking in pregnancy. This data will be collected to identify interventions that can be utilized statewide to decrease smokin				X

b. Current Activities

Currently, 27 cities/counties in Kentucky have smoke free laws covering approximately 38% of the state's population. The Tobacco Program contracts with the Kentucky Center for Smoke free Policy to provide training and technical assistance to local governments, health departments, and coalitions.

The 2010 youth tobacco survey is now in process.

The DPH provided a free annual Prenatal and Postpartum Training for LHD staff, courses raised awareness and educated staff on the effects of smoking and secondhand smoke exposure during pregnancy.

The GIFTS Leadership Team completed the first year assessment. There was significant interest from several health departments. The Team decided to pilot GIFTS in an urban setting and use a new model that integrates GIFTS into existing programs such as HANDS and Healthy Start. Louisville Metro Health and Wellness Department, Lexington-Fayette County Health Department, and two rural counties in Lake Cumberland District Health Department were began to pilot in April 2010. Training held in January 2010 included new and current GIFTS pilot counties. Training included introduction of the new web-based data collection system.

c. Plan for the Coming Year

The local health departments continue to offer smoking cessation programs/classes and assess every pregnant woman for smoking and exposure to secondhand smoke at each health department visit.

Kentucky's Tobacco Quit Line and www.becomeanex.org will continue to offer counseling and self-help options to Kentuckians. Kentucky's Tobacco Quit Line will offer expanded hours of operation and nicotine replacement therapy will be offered if funds are available.

DPH will provide a free annual Prenatal and Postpartum Training for LHD staff. Courses will be provided to raise awareness and educate staff on the effects of smoking and secondhand smoke exposure during pregnancy.

By October 2010, the GIFTS program will have birth outcomes for the first two years of the 9 original pilot counties. The original pilot counties will begin integrating GIFTS into existing programs such as HANDS and Healthy Start. One full time person will continue to coordinate GIFTS activities in those counties.

The Diabetes DAART program to encourage diabetes educators to provide brief interventions and referrals to patients will continue in 2010-2011. Referrals and toolkit completion will be monitored.

The 24/7 Tobacco-Free Schools campaign will continue with a local emphasis on smoke free laws and targeted media in areas working toward both policies

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.9	7	7	8	8
Annual Indicator	7.9	10.0	10.6	9.2	8.1
Numerator	22	28	30	26	23
Denominator	278234	278933	282187	282620	282620
Data Source				KY vital stats death cert files & U.S. census bure	KY vital stats death cert files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.5	7.5	7	7	7

Notes - 2009
2009 data is preliminary and numbers could change. 2009 population estimates are currently not available therefore, 2008 population estimates were used for the denominator.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
2007 data is preliminary and numbers could change.

a. Last Year's Accomplishments
While it is know that teen suicide risk may increase in the wake of a friend or fellow classmate's suicide, experience in Ky has also shown that suicide risk for teens increases following the death of a friend or classmate through unintentional injury such as motor vehicle crashes. If the crash involves fatalities, but the driver or some passengers do survive, the risk appears even greater, and there have been secondary deaths (suicides) following the original tragedy. For this reason, working together as part of the MCH-led Child Fatality Review Program, the state Suicide Prevention program has for several years emphasized the need for early suicide prevention and

mental health intervention for counties in which there are teen motor vehicle crash deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with the Department for Mental Health, Development Disabilities, and Addiction Services on Suicide Prevention Workgroup and Child Fatality Review Team				X
2. Increased public awareness of suicide through media campaigns			X	X
3. Identification and coordination of resources for suicide prevention activities				X
4. Identification of intervention options and training resources				X
5. Enhanced Mental Health initiatives through KIDS NOW!			X	X
6. Well Child and Adolescent Preventive Health training for local health department staff				X
7. Funding through SAMHSA for youth suicide prevention			X	X
8. Kentucky Suicide Prevention members working with school districts to work with survivors, provide resources and create media opportunities				X
9. Through collaboration with the Kentucky Suicide Prevention Group, trained over 3600 people on Question, Persuade, and Refer (QPR) gatekeeper program designed to create awareness about signs and symptoms of a suicidal crisis				X
10.				

b. Current Activities

For 2009-10, when a teen suicide is known from newspaper surveillance, the local county CFR coordinator at the health department or other agency has been contacted as soon as possible by the KIPRC/MCH Injury Prevention Coordinator with information about the state suicide prevention program, how to access them and why their early involvement is recommended.

c. Plan for the Coming Year

The goal for 2010-2011 is to continue this referral effort and to follow the actual utilization of the Suicide Prevention program, asking if they were contacted by the counties to whom that action was recommended.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	64	82	70	55	56
Annual Indicator	60.0	54.6	54.9	54.9	55.8
Numerator	452	419	437	405	411
Denominator	753	767	796	738	737
Data Source				KY vital stats live birth cert files	KY vital stats live birth cert files

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58	58	60	60	62

Notes - 2009
2009 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2009 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2008
2008 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2008 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2007
2007 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2007 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

a. Last Year's Accomplishments
Regionalized Neonatal Care: current status
Kentucky has two true Regional Perinatal Centers. Univerisity of Kentucky in Lexington, serving eastern Kentucky, and Univeristy of Louisville/Kosair Children's Hospital in Lousiville serving the western half of the state. These centers offer comprehensive maternal-fetal and neonatal care, including outreach education, transport, and neonatal developmental follow-up, and a full range of obstetric, pediatric, and surgical sub-bpecialists. The Title V program contracts with the universities to assure all mothers and babies in KY have access to these services. There are two other hospitals in Louisville and one in Ashland with designated Level III neonatal beds. A total of 165 beds are licensed for care under the Level III designation. Due to geography, some KY high risk mothers and babies are also trasferred to border facilities such as Vanderbilt University and

Cincinnati Children's hospital. Additionally, 233 beds are licensed for care under the Level II designation; these hospitals are distributed throughout the state and provide varying levels of service, depending on whether or not they have been able to recruit neonatologist coverage, whichi s difficult in rural areas.

The Office of Certificate of Need within the Cabinet for Health and Family Services is responsible for working with local hospitals to approve numbers and levels of NICU beds. Currently, the Office of Health Policy encourages hospitals to apply for Level II NICU beds, as more beds in rural areas are seen as more accessible care. Applications include a statement that services will be consistent with the State Health Plan and National Guidelines for Perinatal Care, Sixth Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. However, once the CON is obtained, there is no reporting or oversight of these units. According to the State Health Plan, the number of Level III NICU beds is determined by a calculation based on the total annual births in the state while the number of Level II NICU beds is based by calculation using the number of total annual births to an area development district. Definitions for Levels of care have not changed since originally established, and discussions are now underway on how the Cabinet should revise the state health plan and update those definitions to the definitions recommended by the American Academy of Pediatrics in 2004, and currently in the most recent Guidelines for Perinatal Care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. On-going training for health professionals working with neonates				X
2. Collaboration with Office of Health Policy on revisions to the State Health Plan regarding perinatal care				X
3. Collaboration with the Office of Inspector General regarding new hospital licensing regulations for perinatal care servcies				X
4. Preconceptual health services through WIC, prenatal services, folic acid supplements			X	
5. Collaboration Family Planning and preconceptual health counseling	X		X	X
6. Support of maternity and prenatal servcies through the local health department	X		X	
7. Encouraging Early Entry into prenatal care	X		X	
8.				
9.				
10.				

b. Current Activities

The Department for Public Health does not have responsiblity for the State Health Plan nor the CON process, but is assisting other cabinet agencies with information as requested. DPH has continued to encourage the development of a Perinatal Quality Collaborative in the state, but so far there is little progress. Kentucky has established a KY Group report in the Vermont-Oxford data system for those KY hospital who choose to participate.

DPH has established two pilot FIMR program in Jefferson and Warren counties. These programs will look at systems of perinatal care at the local level. KY is also expanding Healthy Babies are Worth the Wait, a community-based prematurity prevention project which includes patient safety and quality improvement initiatives in participating hospitals.

c. Plan for the Coming Year
The Cabinet plans to gather additional information and re-consider updating the state health plan in regard to neonatal/perinatal care. The Office of Inspector General is considering licensure regulations to adapt KY's process to the new definitions of perinatal levels of care.

The Title V program, through contracts with the Regional Perinatal Centers, is engaging univeristy perinatal leaders to assist them in providing a leadership role in the establishment and ongoing maintenance of collaborative perinatal quality projects involving the hospitals in their regions.

The Healthy Babies are Worth the Wait project is expanding to four new sites, and once established, will engage all 7 hospitals in collaborative quality improvement projects.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	78	80	75	76
Annual Indicator	73.5	72.5	72.4	72.5	71.2
Numerator	39414	40927	41103	39860	37796
Denominator	53646	56443	56749	55003	53094
Data Source				KY Vital Statistics Live Birth Certificate files	KY Vital Statistics files, live birth cert files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	73	73	74	74	74

Notes - 2009
2009 data is preliminary and numbers could change

Notes - 2008
2008 data is preliminary and numbers could change

Notes - 2007

2007 data is preliminary and numbers could change.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2007 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

a. Last Year's Accomplishments

At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed. This information and process was emphasized during a nurses meeting through a live video conference available to all LHD nurses and at the annual Prenatal and Postpartum Training provided to the LHD nursing staff.

Local health department staff provides counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program. In addition, local health department staff will make an appointment or a referral for the pregnant woman for prenatal services, as well as assisting Medicaid eligible pregnant women to access services.

Some local health departments have paid for prenatal services out of their community funds for uninsured pregnant women (i.e., the undocumented Hispanic population). This financial burden has been greater in some counties than others. The Division of Maternal and Child Health has attempted to alleviate some of this financial burden by allocating specified funds to the local health departments.

The DPH conducted a second PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study following the guidelines from the Centers for Disease Control and Prevention (CDC) PRAMS core and standard questionnaires. Questions on access to care were included in the PRAMS Pilot survey and approximately 1600 surveys were sent out and sampling was conducted from March through October.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support fo maternity and prenatal services through the local health department funded by Title V	X			
2. Presumptive Medicaid eligibility for pregnant women in collaboration with Medicaid Services		X		X
3. Continuation of Substance Abuse Cessation project funding through KIDS NOW!				X
4. Collaboration between Comprehensive Care Centers (Kentucky's mental health providers) and local health				X

departments				
5. HANDS Home Visitation services		X	X	
6. Tobacco cessation for pregnant women including the Quit-Line	X	X		
7. Centering Pregnancy Programs		X	X	
8. Healthy Start program in Whitley County and the Louisville Metro area		X	X	
9.				
10.				

b. Current Activities

All local health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist eligible prenatal patients access temporary prenatal benefits upon positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to outpatient prenatal services while their application for full Medicaid benefits is being processed. This information and process is emphasized at the annual Prenatal and Postpartum Training provided to the LHD nursing staff.

The data from the second PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study is being analyzed and a report will be available in 2010. If CDC grant funding becomes available in 2010, the Department for Public Health will plan to apply.

The FY10 contract between the University of Kentucky Area Health Education Center (AHEC) and the North Central AHEC was renewed to 1) educate Latino and African-American individuals about culturally relevant health promotion topics including preterm birth prevention; 2) develop and maintain a network of trained lay health workers to disseminate culturally and linguistically appropriate information about health;3) develop and maintain cooperative relationships with community groups and coalitions to enable the north Central AHEC to respond appropriately to health care needs of the target populations using "Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit.

c. Plan for the Coming Year

At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed. This information and process will be emphasized at the annual Prenatal and Postpartum Training provided to the LHD nursing staff.

The health department staff is educated and encouraged to begin referral for prenatal care upon a positive pregnancy test. Continuing education will be provided to the health department staff regarding Presumptive Eligibility to help ensure early access to prenatal care.

Local health departments and communities will be encouraged to emphasize prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.

Upon the data analysis and release of the 2010 PRAMS report, this information will be reviewed and further interventions will be identified that can be utilized statewide to increase early entry into prenatal care.

D. State Performance Measures

State Performance Measure 1: *Decrease the death rate for children age 0-18 due to unintentianal injury and/or violence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		9	9	9	15
Annual Indicator	10.9	21.3	17.4	17.4	16.9
Numerator	114	225	184	185	180
Denominator	1049314	1056466	1058380	1064128	1064128
Data Source				KY Vital Statistics Death Certificate Files and U.	KY Vital Statistics files, death certificate files
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14	14	12	12	

Notes - 2009
For consistency in reporting of this indicator, ICD10 codes were based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data. In past years, the same ICD10 codes may not have been used and this could have caused the rise in the death rates.

For years 2006 and forward, ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0.

Data Source: KY Vital Statistics Files, Death certificate files, & U.S. Census Bureau Population Estimates for KY. 2008 Population estimates were used for 2009 as 2009 estimates are currently not available.

Notes - 2008
2008 data is preliminary and numbers could change.

For consistency in reporting of this indicator, ICD10 codes were based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data. In past years, the same ICD10 codes may not have been used and this could have caused the rise in the death rates.

For years 2006 and forward, ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0.

Data Source: KY Vital Statistics Files, Death certificate files, & U.S. Census Bureau Population Estimates for KY.

Notes - 2007
2007 data is preliminary and numbers could change.

For consistency in reporting of this indicator, ICD10 codes were based on the Unintentional injury and violence codes as used in the CDC WISQARS reporting tool beginning with the 2006 data.

In past years, the same ICD10 codes may not have been used and this could have caused the rise in the death rates.

For years 2006 and forward, ICD10 codes used in calculating this indicator were: V01-X59, Y85-Y86, X60-X84, Y87.0, X85-Y09, Y87.1, Y35, and Y89.0.

Data Source: KY Vital Statistics Files, Death certificate files, & U.S. Census Bureau Population Estimates for KY.

a. Last Year's Accomplishments
In addition to the work of DCBS regarding child deaths related to abuse and neglect, DPH Child Fatality Review and Injury Prevention program review child deaths and support local child fatality review teams and health departments with prevention strategies for other injury causes such as drowning, fire, poison and suffocation.
CFR uses information and materials from National Center for Child Death Review and the Children's Safety Network.

In 2008-9, checkups and education on how to install car seats/ booster seats were provided to families of 748 Kentucky children by the KY State Safe Kids Coalition and its 5 rural county chapters. Despite the eradication of all Safe Kids state-level funding for the Buckle Up program due to the recession, in 2009-10 these same services were offered to families of more than 877 children. MCH is the lead agency for the KY State Safe Kids Coalition, which primarily serves as the coordinator and umbrella for rural county health and police department-based Safe Kids Chapters. Safe Kids injury prevention efforts in KY are augmented by the additional independent efforts of 3 larger urban Safe Kids Coalitions and one rural health Department District Safe Kids Coalition. While the KY State Safe Kids has emphasized car seat and booster efforts especially as we continue to work toward full implementation of the newly passed booster bill, a number of those Safe Kids partners outside of the State Coalition also conducted seat belt safety education and events for tweens.

Another major effort of the KY State Safe Kids Coalition is working to maintain a cadre of nationally-certified child passenger safety (CPS) technicians to assist families. In 2008-9, KY State Safe Kids sponsored (and paid for with Safe Kids Buckle Up funds) a 4-day CPS certifying class for Kentucky State Police (KSP) troopers, which included at least one trooper from every post in Kentucky. Special emphasis was also given to ensuring that KSP were familiar with the new booster bill and could assist in local education/implementation. Two additional 4-day national CPS certifying classes in geographically dispersed areas were given that year. In 2009-10, two 4-day CPS trainings were conducted, along with 2 recertification classes for previously-certified CPS techs and one update class to upgrade the knowledge and skills of rural CPS techs.

Implementation efforts of Booster bill- In 2008-9, the newly passed state booster bill generated warnings only, with ticketed enforcement starting in July 2009: In the summer of 2008, MCH/KIPRC pediatric injury staff and the state Booster Coalition wrote a letter to all local health departments explaining the new bill and including resource links in Spanish and English. After 7 years of leadership for the statewide KY Booster Seat Coalition within KIPRC, leadership was transferred to another local Safe Kids member and agency, but the KIPRC pediatric injury staff continue to be active members and have successfully written two Safe Kids legislative enforcement grants in partnership with other Safe Kids Coalitions across Kentucky, for a total of several thousand dollars. This funding was utilized in 2008-9 to purchase a training DVD on booster seats and booster law for every single law enforcement agency across the state of KY.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Child Fatality Review and Injury Prevention program.				X
2. Healthy Start in Childcare program working with preschools, assuring training and safety in the preschool setting.				X
3. Injury Prevention Partners including Safe Kids Coalitions, Poison Control Center, the SIDS Alliance, Kentucky Injury Prevention Research Center, and Kentucky Center for School Safety.				X
4. HANDS voluntary home visitation program	X	X		
5. Substance Abuse education and treatment	X	X		
6. Passage of Child Booster Seat Bill; legislation for Safe Haven, ATV Helmet useage, Graduated Driver's License, and Primary Seatbelt				X
7. Partnership with the Department for Education for Coordinated School Health				X
8. Partnership with Prevent Child Abuse Kentucky and the Department for Community Based Services				X
9. Training provided to Well Child and Adolescent Preventive Health Nurses and Oral Health providers to recognize the signs of Domestic Violence				X
10. Injury Prevention programs including Child Passenger Safety Seat Checks, ATV and Hunter Safety classes, Back to Sleep campaign, Smoke Alarm usage, Safe Sleep Environment, SIDS, Shaken Baby, Underage Drinking, Bullying,a nd Seatbelt Usage			X	X

b. Current Activities

National fact sheets in English and Spanish on need for boosters and proper use have been widely distributed to local and regional health departments, child care agencies, elementary school family resource centers, children with special health care needs, and foster care workers and families. Booster seat information is a major part of every Fire Safety Day with hundreds of people reached every year. Child care booster seat project- MCH and the MCH/KIPRC pediatric injury staff were asked to work with Child Care on a Federal Stimulus Funds project to distribute booster seats to child care centers that transport low income children. During 2009-10, phone calls were made to 686 centers to gather information on the types of vehicles utilized for child transport. After eligible centers and types of booster seats needed for major vehicles in use were determined, regional trainers were identified and initial orders of booster seats submitted. Local Health Departments and Local CFR teams were aslo provided with technical assistance regarding other causes of injury related death.

Current collaboration with DCBS Protection and Permanency Staff and DPH MCH Staff to develop data sharing for more comprehensive reviews and development of child maltreatment prevention strategies.

c. Plan for the Coming Year

In 2010-11, eligible child care centers will bring their vans to a local or regional training and will receive their seats after 2-hours of training with child care credit on booster seats in general and how to best install theirs in their specific vehicle.

Follow-up is being done with local law enforcement agency data across the state to assess number of citations written, and to provide recognition incentives to police departments that do improve pediatric motor vehicle safety through booster seat citations.

Continue collaboration with DCBS Protection and Permanency Staff and DPH MCH Staff to develop data sharing for more comprehensive reviews and development of child maltreatment prevention strategies.

New Child Fatality Review and Injury Prevention Coordinator at the state level will be developing new strategies to extend collaborative efforts with community partners to enhance the safety of children in KY.

This state performance measure is being discontinued. The data has shown a decrease and portions of this information are captured in Heatlh Outcome Measure 6, Health Status Measure 3A, and National Performance Measures 10 and 16. While this issue remains important it will continue to be monitored in the measures listed above. Additionally a new state performance measure will narrow the focus on children birth to 5 years of age who die from child abuse.

State Performance Measure 2: *Reduce the rate of substantiated incidence of child abuse, neglect, or dependency.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	9.4	14	14	12
Annual Indicator	18.9	19.1	18.5	14.7	14.4
Numerator	18827	19003	18469	14802	14475
Denominator	996407	996407	999531	1008064	1008064
Data Source				Dep. for Community Based Services TWIST database o	Dep. for Community Based Services TWIST data on ch
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	10	10	10	

Notes - 2009
2009 data is preliminary and numbers could change.

a. Last Year's Accomplishments
In 1998 the Department for Public Health developed Health Access Nurturing Development Services (H.A.N.D.S.) an early intervention program in an effort to address and reduce the high rates of child abuse in Kentucky. Modeled after the National Healthy Families America model, HANDS is designed to provide home visitation to over burdened first time parents. HANDS provides education, resources and referral to support first time parents (mom or dad) beginning prenatally and continuing through the first two years of life of a child. These are the building blocks to create the environment for children to live in healthy, nurturing and safe homes and reduce the likelihood of child abuse and neglect over the long term. Families are referred through a screening tool, which leads to a comprehensive assessment conducted by a registered nurse or social worker. Families found to be at-risk are assigned a home visitor through weekly visitation. The caring relationship that is established between the highly trained home visitors and these families is key to the success of the program.

Professional and paraprofessional staff are trained in the comprehensive curriculum based on Growing Great Kids and includes ongoing training required each year to refresh and enhance

their knowledge base. This strength based skill set is used with these high risk families to address topics that include, but are not limited to; pregnancy, infant & child health, safety in the home, decision-making, problem solving, goal setting, parent-child interaction, early brain development and community support.

An independent evaluation is conducted each year by linking HANDS service data with birth certificate date, TWIST data, and MH/MR data and then compared to a similar population. The evaluations have shown lower rates of prematurity and low birth weight, less very low birth weight, and lower infant mortality in teen participants. These outcomes appear to be dose dependent; i.e. those participants who had 16 or more visits had half the premature birth rate of the comparison group. Those who started the program in the first trimester had only 1/3 the rate of preterm births. In addition, evaluations now have demonstrated improved educational status of the mother, improved employment, lower than expected incidence of developmental delay, less ER utilization, and much less substantiated child abuse and neglect than the expected rate.

With the number of families increasing by nearly 300 from the previous year, professional and paraprofessional home visitors completed a total of 154,154 visits in fiscal year 2009. At the end of fiscal year 2009 KIDS NOW reports indicate a total of 11,171 families received HANDS services with 6,181 assessments completed. There were a reported 67,005 professional visits, an increase of 3,608 visits from the previous fiscal year, and 87,149 paraprofessional visits, an increase of 2,439 visits from fiscal year 2008.

DPH has implemented collaborative meetings with DPH and DCBS regarding data sharing between the programs for the purposes of having more complete data that will be more useful for developing prevention/education strategies with the ultimate goal of lowering the rate of substantiated child abuse, neglect, and dependency.
DCBS has initiated many steps toward this goal including increased training for their staff regarding Medical Elements of Child Abuse and Neglect and recogizing risk factors. A community partner, Prevent Child Abuse KY has partnered with DPH, DCBS, and the KY AAP to provide a Child Abuse Recognition Educaiton (CARE) program for physicians and their staff to assist in identification of child abuse and assist in investigation.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuation of HANDS Voluntary Home Visitation Program	X	X		
2. Child Fatality Review Data System for on-going surveillance of child deaths				X
3. Healthy Start in Childcare program to work with preshools, assuring training and safety in the preschool setting				X
4. On-going monitoring of HANDS data and HANDS evaluation process				X
5. KIDS NOW! Early Childhood Mental Health and continuation of the Mental Health in Child Care Initiative				X
6. Training provided to Oral Health providers and local Health Department nurses to recognize the signs of domestic violence				X
7. Substance Abuse education and treatment	X	X		
8. Partnership between the Department for Public Health, the Commission for Children with Special Health Care Needs and the Department for Community Based Services for injury prevention programs	X	X		
9. Partnerships with Kentucky Injury Prevention Research				X

Center, Prevent Child Abuse KY and KY Center for School Safety				
10. Continue Perinatal Depression screening in the HANDS and GIFTS programs	X			

b. Current Activities
HANDS 2.0 web based data collection system underwent major renovations which included updating the infrastructure of the entire system to make it more responsive to upgrades and additions to the structure. Added the HANDS Program Standards Checklist so that 8 technical assistances across the state can electronically enter the findings and central office can generate reports for quality assurance and assist in determining those standards that require targeting as TA's do next fiscal year's annual site visits.

The bi-annual H.A.N.D.S. Academy in Lexington Kentucky with about 300 in attendance. Participants chose from 35 sessions with each offering paraprofessionals and professionals CEUs. With both state and national speakers the topics varied from domestic violence to prematurity.

KY is applying for funding and conducting the home visiting needs assessment for the Materna, Infant, and Early Childhood home visiting program.

Collaborative efforts among the partners include potential development of true prevention programs such as Triple P.

c. Plan for the Coming Year
As we continue to achieve our mission of supporting families as they build healthy, safe environments for the optimal growth and development of children, we will support the HANDS sites across the state with the resources needed to reach the families in their communities and we will continue to build upon and enhance the areas where needs are identified.

Recently, federal health care reform legislation was passed that will provide 5 years of funding for eligible applicants to strengthen and improve coordination of services for 'at risk' communities with maternal, infant and early childhood home visitation. This poses an excellent opportunity for the HANDS program to expand, enhance and/or collaborate with agencies across the commonwealth. This opportunity is being explored to determine the best possible proposal.

Increased collaborative efforts between partners including DPH, DCBS, KY Injury Prevention Research Center, and Prevent Child Abuse KY. In particular the state would like to develop a bureden document and promote more primary prevention initiatives such as Triple P.

This state performance measure is being discontinued, but will be replaced with a more specific measure, focused on MCH's most vulnerable children, those birth to 5 years of age, who die from child abuse with the goal of collaboration resulting in preventive strategies to affect a positive change in this area.

State Performance Measure 7: *Increase the percent of women of childbearing age that present to a local health department that receive a preconceptual service.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective		12	82	82	70
Annual Indicator	77.6	80.6	83.4	69.7	69.7
Numerator	177301	184168	158736	147291	147291
Denominator	228567	228567	190233	211369	211369
Data Source				KY Local Health Dep. reporting system (CDP)	KY Local Health Department service data
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	72	72	74	74	

Notes - 2009
2009 data is currently not available at this time due to problems with the data collection system, therefor, 2008 data is reported.

a. Last Year's Accomplishments
The KY Department for Public Health (DPH) includes many diverse programs that support CDC's preconceptional recommendations by developing interdepartmental initiatives focusing on interconceptional care for women. The collaborative initiatives recognize that preconceptional care should not be limited to a single visit. All DPH health care programs identify that they have an impact on a women's optimal health and potential outcome of any planned or unplanned birth. Opportunities to discuss preconceptional health with patients during each particular program's clinical visits are identified through collaborative agreements during the developmental and approval process for all DPH policies and guidelines.

The Title X Family Planning Program is identified to have the most significant impact by reaching the greatest amount of women through DPH. The Kentucky Family Planning Program, within the Division of Women's Health, offers a full array of reproductive healthcare services for individuals of child bearing age. Funding for family planning services is made available through federal Title X grant funds, which are allocated to local health departments and contracted family planning clinics. Services include: client education, counseling, medical history including reproductive and sexual, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, reproductive health services including breast and cervical cancer screening, and sexually transmitted disease prevention counseling, testing and treatment.

Low-income, under or uninsured females, less than age 21, identified as having abnormal gynecological cancer detecting exams (breast and cervical) are provided treatment via use of Title V funds. Special emphasis on preconceptional health, and benefits of birth spacing is given during the preventive health counseling sessions.
Family Planning clients are provided counseling annually to promote preconception health. Counseling supports the recent CDC recommendations for preconception health.

Special initiatives targeted to service populations identified as having high social and medical risk for unintended pregnancy or poor birth outcomes (i.e. infant death, fetal loss, birth defects, low birth weight, or preterm birth) include: one contracted family planning clinic in Fayette County, Bluegrass Community Health Center (BCHC), targets low income under insured Hispanics, work as migrant farm workers in the bluegrass are. BCHC served 1,399 individuals in CY 2009, adding to the statewide total of 9,385 Hispanic users. This statewide total in Hispanic clients was a 8.8% increase from calendar year 2008; community outreach efforts in urban areas contributed to providing services to 13,694 African/American clients in CY 2009. A targeted Appalachian region known to have a higher STD and teen pregnancy rate, have proven with the Pike County

Male Special Initiative Project that services need to expand beyond the local health department clinic, by reaching not only a college based clinic, but also an in-school program for middle school males who are taught goal setting and self-esteem skills. Total services provided to males age 15 and below were 3,189 and 248 males over age 15. In FY 2010, two additional family planning clinics were awarded Title X supplemental funding for male reproductive services; Coalition for Adolescent Pregnancy Prevention and University of Kentucky Young Parents Program (YPP). CAPP and YPP have served 574 males from July 1, 2009 to December 31, 2009. CAPP and YPP are two central KY contracted family planning clinics which focus on teen pregnancy prevention. In CY 2009 CAPP served 340 females below age 20 and YPP served 1,186 females below age 20. Both agencies provide intensive counseling to teens to prevent teen pregnancies and repeat teen births and also comprehensive adolescent preventive health care services. YPP is unique because it places emphasis on medical, nursing, and nutritional care for both mother and child, education toward better parenting, career and educational counseling, psychosocial support of the family unit; and family planning services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Education and training for health care professionals in cultural diversity				X
2. Family Planning counseling and interconceptual spacing of children	X	X		
3. Access to care and early entry into prenatal care	X	X		
4. WIC and Nutrition counseling	X	X		
5. Substance Abuse education and treatment	X	X		
6. Smoking cessation counseling	X	X		
7. Preconceptual counseling and Folic Acid supplements	X	X		
8. Community outreach efforts targeted to populations identified as having high social and medical risk for unintended pregnancy or poor birth outcomes			X	
9. Targeted services to the Appalachian region to address the high STD and teen pregnancy rates	X	X		
10. Two Central Kentucky initiatives to focus on teen pregnancy prevention				X

b. Current Activities

Kentucky received $ 6,084,692 in federal Title X funding for FY10. Kentucky funds 173 Title X clinics, with the majority of this funding allocated to local health departments to assure access to family planning services throughout Kentucky's 120 counties. Continue interconceptional collaborations with other MCH programs include: a.) All family planning women receiving a pregnancy test also receive a lead exposure verbal risk assessment. Those women identifying with a high risk are recommended for follow up screening; b.) Women of childbearing age are counseled on the importance of folic acid and receive folic acid supplementation; and c.) Kentucky's largest metropolitan area, Jefferson Co benefits from the Healthy Start Program, a federally funded initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes. The program focuses on Five Core Service interventions: direct outreach; case management; health education, interconceptional care; and screening for depression. Additionally, local health departments may opt to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. All Title X delegate agencies must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

c. Plan for the Coming Year
To assure access to comprehensive quality family planning services to individuals, families, and communities through outreach to hard-to-reach or disparate populations and partnering with community-based health and social service providers.

To provide comprehensive reproductive preventive services to enhance the health of Kentucky women and families as demonstrated in improved prematurity rates, STD prevalence, cancer screenings and decreased teen pregnancy and birth rates. To assist women, teens, and men to prevent unintended pregnancy and plan healthy pregnancies.

To help meet these goals, Title X the program must continue to market services through community participation committees and community plans; prepare or recruit additional providers; continue outreach to hard-to-reach and vulnerable populations in non-traditional service sites already established; and expand non-traditional sites to new areas.

This state performance measure is being discontinued. This information is captured in National Performance Measure 18.

State Performance Measure 8: *Reduce the percentage of live births that are preterm.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		16	14	14	14
Annual Indicator	15.0	15.2	15.2	15.1	14.2
Numerator	8398	8793	8961	8255	7811
Denominator	55990	57954	58952	54634	54845
Data Source				KY vital stats live birth cert files	KY vital stats live birth cert files
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	12	10	10	

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
2007 data is preliminary and numbers could change.

a. Last Year's Accomplishments
In the last decade, KY's rate of preterm birth was increasing more than twice as fast as the national rise. After many, many education, awareness, and engagement strategies, the rate is now leveling off. Our most prominent program on prematurity prevention was Healthy Babies Are Worth The Wait, an initiative with March of Dimes and Johnson & Johnson described elsewhere in more detail. While it involed 3 intervention sites and 3 comparison sites, there was a great deal of spill-over from presentations to ACOG, AAP, Perinatal Association, KMA, AWHONN, and other

meetings where perinatal providers gathered. In addition, the project promoted public education with a Community Prematurity Prevention Tool Kit which was utilized by the KY Folic Acid Partnership members in venues all across Kentucky. Statewide prematurity awareness activities performed by the Kentucky Folic Acid Partnership from January 1, 2009 through December 31, 2009 included 240 activities with 1,992,556 participants. While we cannot claim causality, for the year after the program was implemented, KY had the largest decrease in preterm birth of any of our surrounding states and any of the Region IV states except South Carolina.

The Kentucky Perinatal Association hosted its annual conference designed for physicians, nurse practitioners, multidisciplinary perinatal professions, accredited nurse midwives, and social workers interested in learning how to deal with the current issues related to perinatal care. This event was promoted by the Department for Public Health and included topics related to prematurity such as "Progesterone and Preterm Birth", "Impact of Immigration on the Preterm Births", "Hidden Causes of Perinatal Mortality", and "Preterm Birth and Gastrointestinal Complications".

The Kentucky Educational Television station wrote and produced a documentary on Preterm Birth in Kentucky, "Born Too Soon", based on the Healthy Babies are Worth the Wait, HANDS, and Federal Healthy Start programs. It has aired several times and increased public awareness of preterm birth across the state.

The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.
A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to health departments to assist uninsured pregnant women in need of prenatal services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration efforts with Kentucky Perinatal Association and the March of Dimes				X
2. Folic Acid Partnership Statewide Prematurity Awareness campaign			X	
3. HANDS Home Visitation Program	X	X		
4. University partnerships				X
5. Training provided to health care professionals				X
6. Continuing use of a Prematurity Took Kit and as speaker's bureau				X
7. Title V Director's prematurity presentations to professional organizations and consumers				X
8. "Babies are Worth the Wait" expansion to 7 intervention sites in the state	X	X		X
9.				
10.				

b. Current Activities

The MOD is supporting a KY roll-out of Healthy Babies are Worth the Wait, which is now in 7 communities. In addition, there may be a roll-out to other states. Current activities include completing detailed analysis of the data from the original pilot, implementing the program in the four new KY sites, and finalizing manuals and program materials to be posted on the March of Dimes web site.

The Kentucky Perinatal Association continues to addresss prematurity issues and hosted its annual conference promoted by DPH with topics related to perinatal health and Healthy Babies Are Worth The Wait Prematurity Prevention. The KPA has is also scheduling regional conferences in order to reach more busy providers in their local areas.

c. Plan for the Coming Year

The Department for Public Health will provide a yearly Prenatal/Postpartum Training and Prenatal Update for LHD staff with sessions relating to prematurity prevention.
The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.

A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to health departments to assist uninsured pregnant women in need of prenatal services.

The Department for Public Health will encourage the use of the Healthy Babies Are Worth The Wait Prematurity Prevention Tool Kit across the state of Kentucky as a model intervention to assist communities and providers to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention. The use of this toolkit, as well as other educational resources regarding prenatal care and prematurity prevention, are available at the web site, www.prematurityprevention.org

This state performance measure is being retired. Since preterm birth is the leading cause of Infant Mortality, it will be reflected to some extent in Heatlh Outcome Measure 5. However, since the cause of our risiing preterm birth rate in KY is directly related to late preterm births, a new state performance measure will be added to monitor the rate of (singleton) late preterm births in the state.

State Performance Measure 9: *Percentage of foster care children served by the Commission for Children with Special Health Care Needs (CCSHCN)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		20	30	40	6
Annual Indicator	2.5	2.8	4.9	6.4	8.6
Numerator	164	182	368	476	614
Denominator	6600	6600	7500	7414	7150
Data Source				CCSHCN and DCBS Databases	CUP/DCBS snapshot 7/5/09
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	7	8	9	10	

Notes - 2008
CCSHCN Database query: 6/30/08; DCBS FACTS 6/1/08

a. Last Year's Accomplishments
Nurse consultants located in child welfare agency offices continued to serve as health care resources to social service workers during the reporting year, although due to budgetary limitations, CCSHCN's Foster Care Support Section now employs seven (7) nurse consultants as opposed to nine (9). The Northern Kentucky child welfare region is no longer served by CCSHCN staff, and the Cumberlands area is now covered by nurses from contiguous areas.

Children involved in foster care were also able to participate in a dedicated primary care clinic in Lexington, which nearly doubled in enrollment, as well as specialty care clinics statewide. An array of augmentative services by professional staff are also available in a clinical setting. A dedicated Foster Care Support Branch serves as a clearinghouse of information and technical assistance to CCSHCN staff who may have questions. In the past year, foster care nurses attended and presented at a wide variety of conferences and skill-building trainings related to the child welfare setting (for example, Medical Passport; Prevent Child Abuse Kentucky's Child Abuse Recognition & Education). Foster care nurses also provided peer-to-peer insight into the child welfare system to nursing colleagues in the context of providing local training on working with medically fragile resource homes. Foster care nurses have made a special effort to remain visible in all counties in their assigned areas, making visits to all child welfare offices, and attending scheduled foster parent training events and other such activities. In addition to providing case-specific consultation on children in or at risk of out of home care and providing general information on medical concerns noted by child welfare staff, foster care nurses also initiated a formal effort to educate foster parents about and ensure the completion of Medical Passports which track health care provision.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide nursing consultation services	X		X	X
2. Conduct home visits in partnership with DCBS (child welfare) social service workers	X	X	X	X
3. Provide health education to foster families, child welfare workers, and youth	X	X	X	X
4. Provide care coordination for foster children and youth with special health care needs in a specialty clinical setting	X	X	X	X
5. Provide a medical home for foster children in the Bluegrass area	X		X	X
6. Support the creation and maintenance of a medical passport tracking health care provision for children in foster care	X			X
7.				
8.				
9.				
10.				

b. Current Activities
Nurse consultants continue to contribute medical insight on specific child welfare matters as requested.

Numbers served typically fluctuate somewhat based on referrals received. However, nurse consultants are available at any time to the child welfare system. Additionally, the Lexington CCSHCN district continues to house a primary care clinic for foster children (Medical Home for Coordinated Pediatrics), which operates every business day with 24/7 support from the University of Kentucky. The Foster Care Support Branch continues to assist in problem-solving various issues related to the child welfare system for CCSHCN district staff (for example, questions about custody) upon request.

c. Plan for the Coming Year

Previous problems in this area have included service fragmentation/duplication, and a system failure to address the health care needs of the child welfare population. Now that agency roles and goals have been established and clarified, the focus during the coming year will be on data and accountability. Quantifying that the collaboration with child welfare staff is a success will be a goal. While the foster care program is an increasingly relevant program and an important element to CCSHCN activities, the SPM will no longer appear in the five year plan, as a result of other priorities.

State Performance Measure 10: *Percentage of medically fragile foster children served by the Commission.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	45	55	85
Annual Indicator	5.6	85.7	78.1	83.2	87.2
Numerator	9	120	125	129	123
Denominator	160	140	160	155	141
Data Source				CCSHCN and DCBS Databases	CCSHCN/DCBS 10/28/09 & 10/29/09
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	86	86	87	

Notes - 2008

6/4/08 CCSHCN Database census & 6/2/08 DCBS census

a. Last Year's Accomplishments

The percent of children participating in the CCSHCN Medically Fragile Foster Care program as a function of the overall population of medically fragile children increased. Performance as measured by the annual indicator remained comfortably above the goal, for the third consecutive year. Due to a small but significant residual population of foster children who are placed out of state, in 24-hour medically-staffed facilities, or are otherwise ineligible for the program (for example children who are AWOL), participation will never reach 100%. It is felt that the program has reached a maximum capacity for improvement.

Regular communication continued both within the CCSHCN organization and across agency lines with contacts regionally and at the state office levels of the child welfare agency and included periodic newsletters featuring topical field-generated questions and answers, highlighted resources and policy clarification; participation in meetings and conferences; and consultation on

case-specific and more general topics as needed. Additionally, a resource section located on the agency intranet page (viewable by CCSHCN and child welfare staff) was created.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide nursing consultation services	X		X	X
2. Conduct home visits in partnership with DCBS (child welfare) social service workers	X	X	X	X
3. Provide health education to foster families, child welfare workers, and youth	X	X	X	X
4. Assist with care coordination for medically fragile foster children and youth	X	X	X	X
5. Support the creation and maintenance of a medical passport tracking health care provision for children in foster care	X			X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

At this time, the program is fully functional in 112 of the 120 counties in the Commonwealth (excepting the Northern Kentucky region, due to the need to cut expenditures during a state budget crisis), and it is widely acknowledged as a strength in both the public health and child welfare systems. Nurse visitors continue to cultivate relationships with child welfare staff, youth in foster care, and foster parents and become increasingly relevant contributors. Nurse visitors collaborate with the child welfare system's Independent Living Program to ensure transitional information is discussed with families, i.e. transition checklists.

c. Plan for the Coming Year

Future initiatives will flow from upcoming collaboration between agency representatives. Some anticipated directions include the possibilities of overcoming interagency barriers and HIPAA provisions in order to facilitate an even simpler and automated referral process, which would eliminate delayed referrals and service implementation based on child welfare worker paperwork burden. Other activities under consideration include database improvements, continued technical assistance to field staff on qualitative issues, and improved communication with new child welfare central office medical support staff. The top priority for CCSHCN administrators is the continued provision of quality services to medically fragile youth in foster care. As the program nears its quantitative capacity and has been largely successful in this regard, it will be retired as an SPM although will continue as a vital program for CCSHCN.

State Performance Measure 11: *The number of Medicaid covered women who had at least one dental visit during their pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective			28	34	34

Annual Indicator		27.3	32.3	33.3	33.2
Numerator		9588	11972	12332	12481
Denominator		35099	37053	36988	37648
Data Source				KY Medicaid claims data warehouse	KY Medicaid claims database
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	35	36	36	

a. Last Year's Accomplishments

The University of Kentucky College of Dentistry continues the implementation and augmentation of the Centering Pregnancy programs at the Women's Health Center at the Trover Clinic in Madisonville and at the University of Kentucky. The Centering Program provided prenatal education and care for expectant mothers in small, peer-lead groups. Running concurrent to the group sessions are dental care appointments for the participants adjacent to the meeting room. Dental care for these women had emphasis on professional prophylaxis and stringent home care. Referrals for more complicated procedures were made as needed. Their goal continued to be 1000 participants each year. Centering Pregnancy is a national model, developed and tested by Yale University, with positive effects on birthing outcomes. Developments in Kentucky are coordinated with the continuing March of Dimes Initiative and the Department for Public Health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Kentucky Oral Health Program				X
2. Regional Dental Treatment Clinics, Primary Care Centers and local health department's oral health programs	X		X	X
3. Local Health department's prenatal programs	X		X	
4. March of Dimes, Johnson and Johnson Pediatric Institute and Department for Public Health demonstration projects in 3 regions of the state	X			X
5. HANDS Home Visitation Program	X	X		
6. Partnership with University of Kentucky and University fo Louisville Dental schools				X
7. Partnership with Medicaid and Medicaid Dental providers				X
8.				
9.				
10.				

b. Current Activities

The Kentucky Oral Health Program continues to collaborate with community partners to improve the access to oral health care for pregnant women through the Centering Pregnancy with Smiles curriculum. These partners include Frontier Nursing Services at Hyden, the University of Kentucky Center for Rural Health in Hazard, the Women's Health Center in Madisonville's Trover Clinic and the University of Kentucky College of Dentistry.

c. Plan for the Coming Year

The Kentucky Oral Health Program will collaborate with the Kentucky Department for Public Health's Prenatal Program and Medicaid to provide materials and activities targeting both the public and private health care providers regarding the importance of optimal oral health during pregnancy and throughout one's lifetime.

DPH will continue its' partnership with the University of Kentucky College of Dentistry and their work with the Centering Pregnancy With Smiles program and curriculum in the western part of the Commonwealth as well as its expansion to other areas of the state. Centering Pregnancy with Smiles is planned for implementation in the summer of 2009 through the University of Kentucky's College of Dentistry's new partnership with the St. Claire Regional Health System in Morehead, Kentucky.

Through a unique opportunity with the University of Louisville's Medical School and Dental School, the Kentucky Oral Health Program attempt to catalyze the development of a curriculum that will assist obstetricians in the importance of routine and comprehensive dental care in the pregnant patient as well as education and training for the dental professional in the safe and effective management and treatment of the pregnant patient during the prenatal months to optimize the chances of a successful delivery and healthy baby.

The Kentucky Oral Health Program will continue to encourage dental screening and needed oral care for pregnant women in the Commonwealth through outreach activities and continued dissemination of pertinent studies and educational material to a list serve of identified oral health contacts in the local health departments.

Through a unique opportunity with the University of Louisville's Medical School and Dental School, the Kentucky Oral Health Program attempt to catalyze the development of a curriculum that will assist obstetricians in the importance of routine and comprehensive dental care in the pregnant patient as well as education and training for the dental professional in the safe and effective management and treatment of the pregnant patient during the prenatal months to optimize the chances of a successful delivery and healthy baby.

Kentucky's Medicaid Program will continue to include full mouth debridement for pregnant beneficiaries as a covered service.

E. Health Status Indicators

Introduction

Kentucky uses the Health Status Indicators for evaluation and monitoring of many of our MCH efforts. In providing information to the public, KY uses the HSI in combination with selected Healthy People (HP) 2010 goals to provide a context for the public to see how KY does in comparison to national goals. DPH adopted selected HP 2010 goals as Healthy Kentuckians 2010 goals in 2000, and recently has completed a Mid-Decade review and update of nearly 1000 measures and whether or not the state is making progress towards them. This is particularly useful during the legislative sessions, and does guide our direction in state public health efforts.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.1	9.1	9.1	9.0	8.8
Numerator	5072	5270	5355	5147	4828
Denominator	55990	57929	58959	56892	55140
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
KY's trend for LBW has been stable; while the 2008 and 2009 numbers are promising, they are still provisional data. Of the LBW rates, 7.6% are from LBW and 1.6% are VLBW. Insights from our PRAMS pilot are informing our efforts for this longstanding MCH issue. Our focus for interventions has been the overlapping problem of preterm birth.

WIC continues to be one of our strongest interventions and in this economy, is serving record numbers of mothers and infants. KY was one of the first states to implement the new food packages and ix expanding the Farmer's maket program so that participants can access fresh fruits and vegetables. The new VENA approach (Vale-Enhanced Nutrition Assessment) is a more client centered, motivational interviewing type approach and should be more effective in addressing the barriers of pregnant mothers to good nutrition. Since food insecurity is one of the major sources of chronic stress in pregnancy, the WIC program plays a major role as a protective factor and reduces that stress.

Smoking has a huge impact on the LBW rates in KY. The GIFTS (Giving Infants and Families Tobacco Free Starts) program was implemented in 2008 in nine eastern KY counties where smoking in pregnancy was most prevalent, and had the heaviest smokers. Within two years of the program implementation, 22.7% of the 847 participants quit smoking. By the fall of 2010, DPH plans to have birth outcomes for the first two years of the program from the original nine counties. Since 2010, this program has expanded to 4 additional counties.

Participants in the HANDS home visiting program, according to independent evaluators, also have less low birth weigh infants than a comparison group. This program is most successful when mothers get enrolled early in the pregnancy and get 16 or more visits. This is a strengths-based program that addresses social as well as health issues, and builds skills and resillence in the pregnant mother for dealing with her life situation, however stressful it may be. The wholistic approach including the social determinants of health may explain the positive impact on Low Birth Weight, which over the last several decades has been relatively resistent to medical interventions alone. We look forward to enhancing this program with new home visiting grants from health care reform.

In our PRAMS pilot, 98% of Kentucky mothers surveyed knew early prenatal care was important, but 15% were unable to get prenatal care as early as they wanted. Of those, 40% did not have resources or coverage to access care. Health care reform may improve this situation.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.3	7.5	7.6	7.4	7.1
Numerator	3961	4145	4256	4091	3819
Denominator	54140	55226	56350	55176	53441
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
The trend for singleton LBW is relatively stable, and may be decreasing. In Kentucky, only 3.1% of total births are multiples, and <1% of total births are the result of Assistive Reproductive Technology. There has only been a slight increase in multiples over the last decade, and our rising rates of preterm birth have been due to singletons.

Singleton preterm births, which overlap with LBW, have been the focus of "Healthy Babies are Worth the Wait", a Prematurity Prevention Partnership with National March of Dimes and Johnson & Johnson Pediatric Institute. The goal is to maximize all of the services in the community that can help lower the rates of preterm birth. Six hospitals representing diverse geographic regions are participating in the project. These hospitals were divided into three Intervention sites that implemented the use of the toolkit and the other three comparison sites began utilizing the toolkit and interventions starting in 2010. Interventions include smoking cessation programs, physician accountability QI initiatives and education regarding scheduled and elective preterm deliveries, continued education to providers and pregnant women regarding oral health and the association of periodontal disease with pregnancy outcomes to name a few. A toolkit,"Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit was developed and is used within the communities of the intervention sites. In 2010, the toolkit will be updated with the most current information. All LHDs are encouraged to emphasize prematurity prevention by using this toolkit. The toolkit and additional resources are available to the providers, community, and patients at the web site www.prematurityprevention.or

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.6	1.7	1.6	1.5	1.5
Numerator	899	990	927	841	805
Denominator	55990	57929	58959	56892	55140
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
This trend has been stable and may be decreasing in KY. This is consistent with our studies of preterm birth, where the rising rates were not predominately from extreme prematurity, but from late preterm births.

KY has two Fetal & Infant Mortality Review programs that have been implemented, which we hope will provide new insights and strategies on factors that lead to VLBW. Fetal and infant deaths from 24 weeks gestation through 1 year of age are reviewed. The two sites are Louisville, which has our highest African-American population, and Bowling Green, where there is a concentration of hispanics. Louisville is also the site of a Federal Healthy Start program which has been successful in reducing LBW in their population, and the Infant Mortality project by the DHP Office of Health Equity, which is looking at contextual and neighborhood factors around LBW, IM, and Preterm birth.

In the HANDS home visiting program, evaluations have shown amost no VLBW infants when mothers enter the program in the first trimester and engage with 16 or more visits (visits are weekly during pregnancy). There are no medical interventions that could produce this effect, reinforcing our belief that interventions must address social determinants as well as medical aspects of health.

However, medical studies are providing new interventions which reduce VLBW. Folic acid has been shown in some studies to reduce early prematurity by 50-70%. Thus the efforts of the KY Folic Acid Partnership and the Folic Acid program in health departments and the Commission have renewed importance in the opportunity to improve birth outcomes. In addition, progesterone given mid-pregancy for women at risk shows promise in reducing early preterm/VLBW infants, especially if used in combination with measurements of cervical length to determine which women are at risk. One of the leading researchers for this national study is an advisor to the KY Healthy Babies are Worth the Wait project and the Title V program.

Lack of coverage is a barrier to getting women into early prenatal care which could prevent some of these VLBW deliveries. In addition, some studies have shown significant impact in reducing a second very premature birth/VLBW by identifying women with a previous preterm birth and providing them access to care (medical card0 and case management for 24 months after the preterm birth. Health care reform may provide opportunities to develop better programs that would allow these interventions on a regular basis for pregant women, which could result in improved birth outcomes and fewer VLBW infants

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.3	1.4	1.3	1.2	1.2
Numerator	681	770	742	644	627
Denominator	54140	55226	56350	55176	53441
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
This preliminary data appears to show improvement, but it is too early to tell. Interventions and programs are discussed under Health Status Indicator 02A

Local health department (LHD) staff continue to counsel pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and make appropriate referrals to the HANDS program. All pregnant women receiving services at LHDs are screened at each visit for the use of alcohol, tobacco and drug use, as well as exposure to secondhand smoke, and educated about preterm birth, nutrition, weight gain, exercise and dental care.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.6	9.7	6.9	7.9	9.1
Numerator	104	80	57	66	76
Denominator	823524	824209	828157	833890	833890
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

2009 data is preliminary and numbers could change.

2009 population estimates are currently not available therefore, the 2008 estimates were used for the denominator.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
Kentucky has seen an increase in its death rate of unintentional injuries among children aged 14 and younger. DPH's HANDS program staff educates parents on injury prevention strategies such as Safe Sleep to prevent SIDS and co-sleeping fatalities. Local Health Departments utilize many injury prevention strategies to educate their patients/families as well as the community in an effort to reduce the number of fatalities due to drowning, fire, and poisoning. The State Child Fatality Review Team has benefited by collaboration with Chief Medical Examiner, Dr. Tracey S. Corey and Dr. Melissa Currie, Kentucky's only Forensic Pediatrician. These collaborative efforts have heightened awareness of prevention strategies in the areas of SIDS and child maltreatment prevention through increased interaction with the State CFR Team and groups such as the KY Coroner's Association. For further information on KY child abuse prevention efforts please see State Performance Measure 2. Annually the State Child Fatality Review and Injury Prevention program publishes an annual report which includes information on injury prevention strategies that is distributed to the Governor, Chief Justice of KY Supreme Court, and the Legislative Research Commission, local health departments, the county coroners, and posted on the program's website. The Child Fatality Review and Injury Prevention program in the Division within DPH and DCBS Child Safety Branch have begun a collaboration to strengthen child maltreatment prevention strategies. DPH continues to work with Safe Kids Kentucky, the Kentucky Injury Prevention and Research Center, the National Violent Death Reporting System and partners of the like to increase education on prevention strategies.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.0	4.6	2.5	2.9	2.8
Numerator	41	38	21	24	23
Denominator	823524	828830	828157	833890	833890
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

2009 population estimates are currently not available therefore, 2008 population estimates were used for the denominator.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
See National Performance Measure 10.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	37.5	33.4	26.7	27.4	26.6
Numerator	213	207	165	152	148
Denominator	567982	619836	616889	555568	555568
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is preliminary and numbers could change.

2009 population estimates are currenly not available therefore, 2008 population estimates were used for the denominator.

Notes - 2008
2008 data is preliminary and numbers could change.

Notes - 2007
Data from 2007 is preliminary and numbers could change.

Narrative:
The death rate of unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years in Kentucky has shown a decrease for the 5th consecutive year. These decreases can in part be due to the primary seat belt law that was passed in the last 5 years. But also contributing to the decrease is the Graduated Driver's Licensing (GDL) law. This law, passed in 2006, aims at educating our youth on safe driving habits. These education efforts continue even today and include getting the word of GDL into schools and to parents. HB 415 includes provisions to prohibit text messaging, instant messaging, and e-mailing while operating a motor vehicle. It also prohibits cell phone use while driving if the driver is under eighteen years of age.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	142.1	142.1	136.0	129.5	129.5
Numerator	1174	1174	1126	1080	1080
Denominator	826015	826015	828157	833890	833890
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data is currently not available at time of submission therefore 2009 data actually reflect year 2008.

2009 population estimates are currently not available therefore, 2008 estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change.

Narrative:
DPH's HANDS program staff educates parents on injury prevention strategies and completes them in completing a home injury prevention checklist to heighten parents' awareness of possible hazards in their home. The Healthy Start in Childcare Program aides childcare centers in identifying playground hazards. The Childhood Lead Poisoning Prevention Program decreases unintentional injuries through the local health departments educating parents on lead poisoning prevention strategies regarding safe toys and other hazards. The Well Child and School Health programs aide in educating school based staff on creating a safe environment for children within the school. Local Health Departments utilize many injury prevention strategies to educate their patients/families as well as the community in an effort to reduce the number of injuries. For further information on KY child abuse prevention efforts please see State Performance Measure 2. Annually the State Child Fatality Review and Injury Prevention program publishes an annual report which includes information on injury prevention strategies that is distributed to the Governor, Chief Justice of KY Supreme Court, and the Legislative Research Commission, local health departments, the county coroners, and posted on the program's website.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	22.5	22.5	15.7	18.7	18.7
Numerator	186	186	130	156	156
Denominator	826015	826015	828157	833890	833890

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data is currently not available at time of submission therefore, the 2009 numbers actually reflect year 2008.

2009 population estimates are currently not available therefore, 2008 estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change.

Narrative:
Please see information found in indicator 3B.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	141.6	141.6	125.2	112.3	112.3
Numerator	828	828	701	624	624
Denominator	584540	584840	559766	555568	555568
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data is currently not avaiable at time of submission therefore the 2009 numbers actually reflect year 2008.

2009 population estimates are currently not available, therefore, the 2008 estimates were used for the denominator.

Notes - 2007
2007 data is preliminary and numbers could change. The 2007 file is not complete as data from a few hospitals is missing. Health Policy does not anticipate having a complete file reflecting all hospitals until mid August. This years indicator will be updated next year to reflect appropriate numbers.

Narrative:
See Health Status Indicator 3C.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	18.2	18.6	17.7	25.3	28.0
Numerator	2445	2528	2428	3471	3851
Denominator	134356	135840	137048	137431	137431
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 population estimates are not currently available through the U.S. Census Bureau therefor, 2008 estimates are being used for 2009.

Reporting of cases from both private and public providers has improved and more reports are being received which accounts for the increased rate.

Data Source: KY Dep. for Public Health, Division of Epidemiology and Health Planning, Sexually Transmitted Diseases Branch, Surveillance Section.

Notes - 2008
Reporting of cases from both private and public providers has improved and more reports are being received which accounts for the increased rate.

Data Source: KY Dep. for Public Health, Division of Epidemiology and Health Planning, Sexually Transmitted Diseases Branch, Surveillance Section.

Narrative:
The Infertility Prevention Program targets Chlamydia screening to women receiving family planning services and are between the ages of 15-24. All women who present to STD clinics are screened for Chlamydia.
• The amplified testing procedure that is currently utilized for Chlamydia detection is far more sensitive than prior procedures. As a result, more positive results are being found among persons tested. Consequently, increased reporting for Chlamydia has occurred.
• The time span between specimen collection and treatment date is currently being monitored to ensure timely treatment of infected individuals, which will stem the spread of disease.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.7	4.8	4.9	6.7	7.6

Numerator	3434	3542	3575	4876	5476
Denominator	735723	731707	728904	724479	724479
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
2009 population estimates are not currently available from the U.S. Census Bureau, therefore, 2008 estimates are being used.

Reporting of cases by private and public providers has improved as more reports are being received which accounts for the increase.

Data Source: KY Dep. for Public Health, Division of Epidemiology and Health Planning, Sexually Transmitted Diseases Branch, Surveillance Section.

Notes - 2008
Reporting of cases by private and public providers has improved as more reports are being received which accounts for the increase.

Data Source: KY Dep. for Public Health, Division of Epidemiology and Health Planning, Sexually Transmitted Diseases Branch, Surveillance Section.

Narrative:
Women above the age of 24 are screened if they are at increased risk, such as multiple sex partners, exposure to an infected partner, or history of a prior STD. All women who present to STD clinics are screened for Chlamydia.
• The amplified testing procedure that is currently utilized for Chlamydia detection is far more sensitive than prior procedures. As a result, more positive results are being found among persons tested. Consequently, increased reporting for Chlamydia has occurred.
• The time span between specimen collection and treatment date is currently being monitored to ensure timely treatment of infected individuals, which will stem the spread of disease.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	57714	48946	5776	178	869	45	1900	0
Children 1 through 4	230073	196191	22381	710	3327	212	7252	0
Children 5 through 9	277375	239097	26321	816	3541	242	7358	0
Children 10	275155	240266	25836	643	2649	151	5610	0

through 14								
Children 15 through 19	291538	253189	30633	756	2523	182	4255	0
Children 20 through 24	296473	259148	29331	877	3524	178	3415	0
Children 0 through 24	1428328	1236837	140278	3980	16433	1010	29790	0

Notes - 2011

Narrative:
Based upon the latest census data (2008), births in Kentucky total 56,892, which is a 1.7% increase from 2007. Thepercentage of births to white and African American mothers has remained fairly consistent while there has been an increase or more than six - fold in Hispanic births from 473 in 1995 to 2873 in 2008.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	45952	2994	0
Children 1 through 4	184803	11388	0
Children 5 through 9	228140	10957	0
Children 10 through 14	232356	7910	0
Children 15 through 19	246029	7160	0
Children 20 through 24	251171	7977	0
Children 0 through 24	1188451	48386	0

Notes - 2011

Narrative:
Based on population estimates from 2008, the Hispanic population in Kentucky is 101,981 which is an increase from the previous year. Total Hispanic females in 2007 in Kentucky are estimated to be 44,821 and 3,108 are infants.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	160	80	57	18	0	0	0	5
Women 15	2034	1619	326	4	2	5	0	78

through 17								
Women 18 through 19	5022	4174	639	8	1	17	0	183
Women 20 through 34	42869	36552	3979	49	221	504	0	1564
Women 35 or older	5055	4194	362	1	79	106	0	313
Women of all ages	55140	46619	5363	80	303	632	0	2143

Notes - 2011

Narrative:
Kentucky has had an increase in numbers of births over the past few years. In 1995, the toal number of live births was 52,054 compared to a total of 56,892 in 2008. The percentage of births to white and African - American mtohers has remained fairly consistent while htere has been an increase in hispanic births. In 1995, there were 473 birhts to individuals of Hispanic origin compared to 2,873 in 2008.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	72	8	0
Women 15 through 17	1919	113	2
Women 18 through 19	4764	258	0
Women 20 through 34	40589	2258	22
Women 35 or older	4661	267	207
Women of all ages	52005	2904	231

Notes - 2011

Narrative:
Kentucky has had an increase in numbers of births over the past few years. In 1995, the toal number of live births was 52,054 compared to a total of 56,892 in 2008. The percentage of births to white and African - American mtohers has remained fairly consistent while htere has been an increase in hispanic births. In 1995, there were 473 birhts to individuals of Hispanic origin compared to 2,873 in 2008.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	287	231	50	0	1	3	0	2
Children 1 through 4	61	48	13	0	0	0	0	0
Children 5 through 9	30	25	4	0	0	0	0	1
Children 10 through 14	46	42	4	0	0	0	0	0
Children 15 through 19	166	138	24	1	1	2	0	0
Children 20 through 24	269	230	33	1	0	3	0	2
Children 0 through 24	859	714	128	2	2	8	0	5

Notes - 2011

Narrative:
Addressing this issue includes the development of the Jefferson County Infant Mortality Project, in conjunction with the Center for Health Equity based at the Louisville Metro Department of Public Health and Wellness. This project determines the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American Women in the Jefferson County communities. Also, the Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age are reviewed.

Review of deaths of older children is conducted by the state and local Child Fatality Review Teams. Deaths are reviewed for identification of causes of death in order to determine prevention strategies. Also, in collaboration with the University of Kentucky, the Kentucky Injury Prevention Research Center gathers and analyzes data to identify trends, patterns and risks, provides technical assistance and training to local Child Fatality Review Teams, while also reviewing data provided by the Child Fatality Review Teams.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	277	10	0
Children 1 through 4	56	5	0
Children 5 through 9	29	1	0
Children 10 through 14	45	1	0
Children 15 through 19	160	6	0
Children 20 through 24	258	11	0

Children 0 through 24	825	34	0

Notes - 2011

Narrative:
Addressing this issue includes the development of the Jefferson County Infant Mortality Project, in conjunction with the Center for Health Equity based at the Louisville Metro Department of Public Health and Wellness. This project determines the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American Women in the Jefferson County communities. Also, the Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Fetal and infant deaths from 24 weeks gestation through 1 year of age are reviewed.

Review of deaths of older children is conducted by the state and local Child Fatality Review Teams. Deaths are reviewed for identification of causes of death in order to determine prevention strategies. Also, in collaboration with the University of Kentucky, the Kentucky Injury Prevention Research Center gathers and analyzes data to identify trends, patterns and risks, provides technical assistance and training to local Child Fatality Review Teams, while also reviewing data provided by the Child Fatality Review Teams.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1131855	977689	110947	3103	12909	832	26375	0	2008
Percent in household headed by single parent	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	9.6	7.1	2.4	0.0	0.1	0.0	0.1	0.0	2009
Number enrolled in Medicaid	538701	429480	75417	1725	3151	1042	0	27886	2009
Number enrolled in SCHIP	90731	78176	10858	262	697	165	0	573	2009
Number living in foster home care	7012	5427	1299	12	4	13	0	257	2009
Number enrolled in food stamp program	1004536	848385	145065	2528	4936	1723	1899	0	2009
Number enrolled in WIC	134984	116918	16612	132	402	912	0	8	2009
Rate (per	343.2	267.8	872.5	128.9	154.9	120.2	784.8	0.0	2009

100,000) of juvenile crime arrests									
Percentage of high school drop-outs (grade 9 through 12)	2.9	2.6	4.9	3.0	2.3	0.0	0.0	3.5	2009

Notes - 2011
Data is from KIDS count with the Annie E Casey Foundation and not available by race or ethnicity. 2009 data is currently not available, therefore, 2008 data is reported.

Narrative:
The percent in household headed by single parent remains stable for 2008 from previous years, with no differentiation between race reported.

The percent in TANF (Grant) families also remained stable.

The number enrolled in Medicaid has increased from 2008. In addition to economic decline affecting enrollment, education and awareness of Medicaid eligibility and enrollment has increased through efforts of local health departments throughout the state.

The number enrolled in SCHIP is significantly increased from 2008. Increase due to a statewide KCHIP enrollment initiative, effective November 1, 2008, and the roll out of a mail-in application process to remove barriers to enrollment.

The number living in foster home care shows a slight decrease from 2008.

The number enrolled in food stamp program has significantly increased from 2008 and may be contributed to the decline of the economy, with loss of jobs and increasing food prices.

The number enrolled in WIC has shown an increase attributable again to the declining economy, job losses and increasing food prices.

The rate (per 100,000) of juvenile crime arrests is increased 2008.

The percentage of high school drop-outs (grade 9 through 12) has decreased slightly. The Kentucky Board of Education has increased its attention and focus concerning the high school drop-out rates in Kentucky. The Kentucky Department of Education (KDE) has dedicated efforts across all programs (in everything that they do) to address drop-out issues which includes the provision of guidance, technical assistance, professional development and drop-out prevention grants to schools. In February 2009 America's Promise Alliance partnering with the KDE offered a Drop-Out Prevention Summit in Eastern Kentucky, Mt. Sterling. This Summit brought together the schools, businesses and local community to learn more about this issue which included keynote speaker John Bridgeland of the "The Silent Epidemic". First Lady Jane Beshear hosted "Graduate Kentucky: A Community Approach" which was a state-wide drop-out prevention summit in September 2009.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	937280	40409	0	2009
Percent in household headed by single parent	0.0	0.0	33.0	2008
Percent in TANF (Grant) families	9.2	0.4	0.0	2009
Number enrolled in Medicaid	489601	23041	26059	2009
Number enrolled in SCHIP	86627	3723	381	2009
Number living in foster home care	6131	291	590	2009
Number enrolled in food stamp program	970388	34366	0	2009
Number enrolled in WIC	124240	11889	8	2009
Rate (per 100,000) of juvenile crime arrests	406.7	180.7	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	4.1	0.0	2009

Notes - 2011

Narrative:
The percent in household headed by single parent remains stable for 2008 from previous years, with no differentiation between race reported.

The percent in TANF (Grant) families also remained stable.

The number enrolled in Medicaid has increased from 2008. In addition to economic decline affecting enrollment, education and awareness of Medicaid eligibility and enrollment has increased through efforts of local health departments throughout the state.

The number enrolled in SCHIP is significantly increased from 2008. Increase due to a statewide KCHIP enrollment initiative, effective November 1, 2008, and the roll out of a mail-in application process to remove barriers to enrollment.

The number living in foster home care shows a slight decrease from 2008.

The number enrolled in food stamp program has significantly increased from 2008 and may be contributed to the decline of the economy, with loss of jobs and increasing food prices.

The number enrolled in WIC has shown an increase attributable again to the declining economy, job losses and increasing food prices.

The rate (per 100,000) of juvenile crime arrests is increased 2008.

The percentage of high school drop-outs (grade 9 through 12) has decreased slightly. The Kentucky Board of Education has increased its attention and focus concerning the high school drop-out rates in Kentucky. The Kentucky Department of Education (KDE) has dedicated efforts across all programs (in everything that they do) to address drop-out issues which includes the provision of guidance, technical assistance, professional development and drop-out prevention grants to schools. In February 2009 America's Promise Alliance partnering with the KDE offered a Drop-Out Prevention Summit in Eastern Kentucky, Mt. Sterling. This Summit brought together the schools, businesses and local community to learn more about this issue which included keynote speaker John Bridgeland of the "The Silent Epidemic". First Lady Jane Beshear hosted "Graduate Kentucky: A Community Approach" which was a state-wide drop-out prevention

summit in September 2009.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	664056
Living in urban areas	621405
Living in rural areas	504216
Living in frontier areas	1581
Total - all children 0 through 19	1127202

Notes - 2011

Narrative:
As births continue to increase in KY so does this particular age group. The geographic make-up of Kentucky is somewhat diverse ranging from plain fields in the west to mountainous regions in the east along with coal fields, farmland, and urban cities in between. The majority of children aged 0-19 live in areas classified as rural. Two counties (Hickman and Robertson) in Kentucky have been identified, based on the definition from the National Center for Frontier Communites of "population density and the distance in miles and travel time in minutes to a market service area", as frontier areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4154968.0
Percent Below: 50% of poverty	7.6
100% of poverty	17.3
200% of poverty	20.1

Notes - 2011

Narrative:
Due to the current economic impact and jobless rate poverty levels have increased in Kentucky. The county with the greatest poverty level is Owsley, situated in the Eastern Coal Field Region. Owsley is one of four of Kentucky's 120 counties designated as one of the Federal Renewal Communities by the US Department of Housing and Urban Development.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	991199.0
Percent Below: 50% of poverty	12.1
100% of poverty	23.5

200% of poverty	45.7

Notes - 2011
Poverty estimates at various levels of the Federal poverty line are not provided for the age range 0-19 as the Census bureau considers children to be less than 18 years of age. Specific poverty data on KY children aged 0-19 cannot be determined based on how the Census Bureau reports the data by age groups. Therefore, estimates shown reflect KY resident children aged 0-17 for year 2008.

Poverty estimates at various levels of the Federal poverty line are not provided for the age range 0-19 as the Census bureau considers children to be less than 18 years of age. Specific poverty data on KY children aged 0-19 cannot be determined based on how the Census Bureau reports the data by age groups. Therefore, estimates shown reflect KY resident children aged 0-17 for year 2008.

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Narrative:
Due to current economic impact and jobless rate in Kentucky, the total population under age 18 living in poverty has increased including those living in the 100-200% rates.

F. Other Program Activities

Other MCH Priorities/ Program Activities

The Division of Maternal and Child Health (MCH) is the state agency responsible for administering Kentucky's Title V program and provides the toll-free hotline mandated by the federal government to provide access to information for parents regarding health care providers and practitioners who provide health care services and other relevant health-related information for Title V and Title XIX services. The hotline is answered within the Child and Family Health Improvement Branch of MCH. Callers receive a live voice during normal business hours and may leave a voice message when the office is closed. Calls are returned as soon as possible. Callers are directed to appropriate program staff when indicated. For instance, calls related to WIC are transferred to the WIC program coordinator in the Nutrition Services Branch; mammogram and women's cancer inquiries are transferred to the Women's Health Division. Prenatal inquiries are handled by the Prenatal Program Coordinator in CFHI Branch or are referred to the local health departments for issues related to specific services.
The majority of calls sent to Women's Health come from patients seeking free or low-cost mammograms or Pap tests. WIC calls typically are inquiries on how to find a local WIC office or how to apply for WIC. It is infrequent that calls regarding prenatal services are received on the hotline. As of January 1, 2010 we have received approximately 1,000 calls.

MCH has notified local health departments of the opportunity for Kentucky women to participate in the National Text 4 Baby initiative. This program communicates with prenatal women and new mothers by texting to their cellular telephones messages to remind them to take their Folic Acid, prenatal vitamins, or that it is time to take their newborn to a provider for routine check-ups or immunizations. To be a recipient of these free messages, women must use specified cellular telephone companies.

KY Early Childhood Systems Collaborative: Kentucky has had structure for both formal and informal collaboration among early childhood partners for over a decade. In 2000, landmark legislation created the Early Childhood Development Authority to oversee and coordinate Kentucky's early childhood programs, and committed 25% of Kentucky's Phase I Tobacco Settlement dollars to fund the early childhood initiative known as KIDS NOW (Kentucky Invests in Developing Success NOW!). The Early Childhood Development Authority is a public-private partnership with diverse membership including many of the agencies listed below as well as child care directors, Head Start directors, United Way, business leaders, and academic experts in early childhood. The group developed a mission, vision and 20 year plan for early childhood programs in Kentucky. KIDS NOW encompasses many early childhood programs across many departments and divisions, including public health, child welfare, mental health, substance abuse, child care, child care subsidy, Child care Quality Rating Systems, Child Advocacy centers, early childhood education & Pre-school, Part C early intervention, Head Start, and Early Childhood professional development. In addition this body oversees 65 Community Early Childhood Councils, who coordinate these services at the local level.. The Early Childhood Development Authority meets quarterly to review the progress of programs including program evaluation results as well as budget. In addition, program leads meet quarterly in "Implementation meetings" to assure collaboration across programs. The HANDS state-wide Home Visiting program has been one of the programs overseen by the Early Childhood Development Authority and integrated into this collaborative. Last year the Governor formed a Task Force on Early Care and Education which has done an inventory of early childhood programs in the state and is currently formulating recommendations for the Governor. In addition, the state is now applying for funding to develop a State Early Childhood Advisory Council, based on the infrastructure and expertise already developed by the Early Childhood Development Authority as described above. The Early Childhood Comprehensive Systems (ECCS) Grant will enhance the the development of a comprehensive plan through a fiscal mapping process which should be completed in early 2011. In addition, early childhood partners in the state are currently collaborating on a systems-building grant for early childhood mental health thru SAMSA in selected areas of the state.

G. Technical Assistance

As a result of information coming out of Kentucky's needs assessment process, we are collaborating with partners from other departments on several issues and would benefit from technical assistance on the following:
(numerical, not priority order)

(1) Assistance on identifying and or developing prevalence data or estimates on the extent of substance abuse at both the state and county level, and assistance with exploring evidence based strategies for primary prevention efforts. In order to objectively and effectively address the issues we must understand clearly where the state is in severity. Clarity of data will assure prevention strategies can be developed and targeted to areas with the highest likelihood for impact. While availablity of treatment is a known issue, it woudl be our hope that primary prevention efforts could decrease the need for such services.

(2) Assistance with exploring models of primary prevention for child abuse and maltreatment, specifically Triple P and possibly others. Child maltreatment is one of the most preventable causes of death for Kentucky children, and a growing need in Kentucky. Although many programs for recognition of child maltreatment currently exist throughout the state, we believe this problem will improve through primary prevention strategies. We have community partnership availble and

interested in testing and implementing such strategies at the community level, and DPH, Dept of Community Based Servcies, and Dept of Behavioral Health are all interested in promoting prevention strategies in communities and at the state level.

(3) Assistance with improving infant mortality data from NCHS or the CDC would benefit our efforts to more accurately determine infant deaths in Kentucky, as our current reporting is likely a significant underestimation of the problem in KY. Without accurate data, it is difficult to raise the importance of infant mortality with policy makers and to develop and target specific strategies to address the issue.

(4) Assistance with redesigning programs to promote resilience and strengths-based approaches. Those programs where we have utilized these approaches are much more successful than traditional programs that are directive and based on our understanding of the problem, not the patient's needs or desires for understanding the problem.

While CCSHCN would like to participate in programs above, we would also like to expand by refining a process to:
1. Collect data on all programs;
2. Evaluate the data;
3. Measure program effectiveness;
4. Provide guidance;
5. Adjust or modify interventions; and
6. Reporting out results to all interested parties.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11322259	12059197	11355963		11354415	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	34967800	34967800	39984700		34342500	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	40131800	39306219	39553100		41333300	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	86421859	86333216	90893763		87030215	
8. Other Federal Funds *(Line10, Form 2)*	117684744	125666205	137314400		144893800	
9. Total *(Line11, Form 2)*	204106603	211999421	228208163		231924015	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	12738461	12696844	12738461		12828132	
b. Infants < 1 year old	12871863	13023510	12871863		12962474	

c. Children 1 to 22 years old	21483222	21413036	21483222		21634451	
d. Children with Special Healthcare Needs	32056924	31952194	32056924		32282586	
e. Others	5982998	5963451	10454902		6025113	
f. Administration	1288391	1284181	1288391		1297459	
g. SUBTOTAL	86421859	86333216	90893763		87030215	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		120200		101100	
c. CISS	140000		102700		140000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	116923300		136178300		144091600	
h. AIDS	0		0		0	
i. CDC	526800		913200		561100	
j. Education	0		0		0	
k. Other						

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	38953442	39019881	48357692		39227650	
II. Enabling Services	24881451	24800162	23318377		25056601	
III. Population-Based Services	16357598	16304157	14671604		16472745	
IV. Infrastructure Building Services	6229368	6209016	4546090		6273219	
V. Federal-State Title V Block Grant Partnership Total	86421859	86333216	90893763		87030215	

A. Expenditures

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provides as accurate information as is possible at that time.

Actual expenditures may also be different than budget because of carryover and the variance of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes. Difference may also be due to additional expenditures related to additional revenue and numerous budget adjustments (both positive and negative) for the year. We are unable to amend expenditures to reflect this. Details are available upon request.

Kentucky has a constitutional amendment requiring a balanced budget at the end of each fiscal year. In the current economic climate, this remains challenging.

Expenditures have remained relatively constant for Title V funds. The exceptions were minor and include:
•Form 3 shows increased expenditures in 2008 under Other Federal Funds due to additional Federal WIC funds and other carry forward dollars were added during 2008.
•Form 4 under All Others in Section 1. Federal-State MCH Block Grant Partnership included Federal funds that cross state fiscal years; these unexpended funds were used in early 2009.
•Form 5 had no significant trends noted since 2008. Funding from the Commission for Children with Special Health Care Needs had been overlooked prior to 2008 and has been included since that time.

B. Budget

Both the Division of Maternal and Child Health (MCH) and the Commission for Children with Special Health Care Needs provide a discussion of the FY11 budget within this section. The majority of Title V Block Grant funding, after giving 34.9% to the Commission, is allocated by the MCH Division to local health departments to support community programs that work toward attaining MCH performance and outcome measures. In addition to MCH Title V funding, the health departments receive revenue from several major sources including other state general funds, federal grants, KIDS NOW Early Childhood Initiative, KCHIP, Bioterrorism, and local tax dollars.

Based upon the current estimated block grant allocations to Kentucky in FY11, (total of $11,354,415) 34.9%, or $3,962,691, will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $7,391,724 will remain with the Department for Public Health.

For FY 11, the majority of this funding will be re-allocated through a block grant process to local health departments. From the allocations, local health departments have the ability to select particular cost centers in which to use the funds, which include clinical (direct patient services) or community (population-based) services. Clinical services include well-child, maternity and prenatal care, family planning, oral health and nutrition services. Approximately 90% of Title V funding is used to cover local health department clinical services. Some of the Community Services implemented by local health departments include prenatal classes, physical activity campaigns in schools, teen pregnancy prevention programs, injury prevention activities and smoking cessation campaigns. Approximately 10% of Title V funding is used to cover community services.

Funding in FY 09 was discontinued to support the Mental Health/Mental Retardation Suicide Prevention personnel ($14,000). This contract was reduced in previous years when the Department of Mental Health Mental Retardation received a $400,000 grant for Youth Suicide Prevention.

Current contractual agreements with major universities assist MCH programs with some direct care and infrastructure services, as well as data tracking and analysis, and education for local health department staff. These contracts are funded partially or entirely by the Block Grant. Funding has continued into FY11 for:

Custom Data Processing	$100,000
UK Infant Intensive Care Project	$260,550
UK Injury Prevention and Research	$112,608
UK MCH Institute	$42,900

UK Prenatal Training	$6,000
UK Young Parents Program	$143,200
UL Child Evaluation Center (Developmental Evaluation)	$422,300
UL High Risk Infant Follow-Up	$260,550
UL Maternal Mortality	$25,300
UL Pediatric Assessment/Well Child Program	$145,920

These contracts have been decreased in recent years and are continuing to decrease reflective of current budget trends.

For many years, DPH has placed special emphasis on physical activity and nutrition services for MCH populations. DPH directs funding to local health departments from the Preventive Services Block Grant, Healthy Communities Grant, and a portion of the Title V MCH Block Grant to underwrite activities addressing the issue of physical inactivity. In addition, $1 Million of the Title V block Grant is allocated for Medical Nutrition therapy in the local health departments, which includes interventions for diabetes and obesity. As obesity is a primary health concern for Kentucky's population, a combined use of these funds supports the ability of local health departments to address the unique needs of their communities.

Local health department allocations are based on a formula that takes into account population and need on a county-by-county basis. Funds are provided for clinical and community health and while certain programs are required (such as family planning, prenatal, SIDS grief counseling, child preventative, adult personal health and medical nutrition therapy), allocations for individual programs may vary depending upon community need as determined by a local needs assessment process. Throughout this process, MCH Title V funds must be used to meet MCH performance measures and applicable 2010 health objectives. The Title V Administrator works with the plan & budget review team who read each local health department plan and verify the proper use of MCH funding as well as the effectiveness of planned activities. Below is a listing of how Kentucky's local health departments are using Title V funding during FY10-FY11. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712) Dental Clinical Services	$385,809 (9%)
(CC 800) Pediatric Well-Child	$3,383,584 (75%)
(CC 802) Family Planning	$278,139 (6%)
(CC 803) Maternity	$2,500 (<1%)
(CC 805) Nutrition	$47,552 (1%)
(CC 818) Community Activities	$289,318 (6%)
(CC 857) Physical Activity	$94,595 (2%)
Total.....	$4,481,497

Other federal funding Kentucky receives for MCH includes:

SSDI	$101,100
CISS	$140,000
WIC & WIC Food	$144,091,600
CDC for Childhood Lead	$561,100
Total…….....	$144,893,800

MCH State non-federal funding includes:

Program	Amount
MCH	$10,031,700
Oral Health	$877,600
KEIS	$13,095,300
Genetics	$469,600

Newborn Screening	$151,600
Nutrition	$50,800
HANDS	$7,719,100
Reach Out and Read	$215,100
Healthy Start in Child Care	$640,100
Early Childhood Mental Health	$775,000
Early Childhood Oral Health	$216,600
Early Childhood KEIS	$100,000

TOTAL: $34,342,500

There are no significant budget variations to report. See Expenditures section for details on variations in expenditures.

Commission for Children with Special Health Care Needs

The fiscal condition of the Commonwealth of Kentucky continues to be compromised as the result of low revenue projections and the rising costs of services. In spite of this situation, CCSHCN has made a commitment to preserve infrastructure and continue to serve those who are most in need. This requires careful prioritization, reliance upon partnerships and a heightened awareness of community resources.

In addition to MCH Title V Block Grant dollars, the CCSHCN receives funding from the state general fund (which includes Tobacco Settlement funds), agency funds, a CDC grant and two HRSA grants. The agency revenues are generated by dividends, a Medicaid cost report settlement, and third party/patient billings for direct patient care and care coordination.

While CCSHCN's total budget for FY2011 has increased by 10% over the FY2006 level, the revenue mix has changed radically. State general funds have decreased by 10.28%, federal funds have decreased by 3.74%, and CCSHCN has had to rely on its ability to generate agency funds which has increased by 49.42%. CCSHCN has been able to do this primarily by decreasing services to the underinsured population and increasing the number of patients with third party insurance coverage. CCSHCN expects these trends in state general funds to continue for a number of years going forward, however, the CCSHCN feels certain that the state and agency funds required for the 1989 maintenance of effort level of $8,170,428 will continue to be available into the foreseeable future.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.